Health, Housing & Community Services
Mental Health Commission

To: Mental Health Commissioners
From: Jamie Works-Wright, Commission Secretary
Date: September, 2021

Documents Pertaining to 9/23/21 Agenda items:

	• Attachment: MHAB Meet the Members.pdf • Attachment: MHAB Bylaws CURRENT.pdf • Attachment: MHAB Bylaws Memo 07.16.2021.pdf • Attachment: MHAB Annual Report July 2021 (Draft).pdf	420 426 432 433

Health, Housing & Community Service Department
Mental Health Commission

Berkeley/ Albany Mental Health Commission

Regular Meeting
Thursday, September 23, 2021

Time: 7:00 p.m. - 9:00 p.m. **Zoom meeting** https://zoom.us/j/96361748103

Public Advisory: Pursuant to Section 3 of Executive Order N-29-20, issued by Governor Newsom on March 17, 2020, this meeting of the Mental Health Commission will be conducted exclusively through teleconference and Zoom Videoconference. Please be advised that pursuant to the Executive Order and the Shelter-in Place Order, and to ensure the health and safety of the public by limiting human contact that could spread the COVID-19 virus, there will not be a physical meeting location available.

To access the meeting remotely: Join from a PC, Mac, and IPad, IPhone or Android device: Please use the URL: https://zoom.us/j/96361748103. If you do not wish for your name to appear on the screen, then use the drop-down menu and click on "rename" to rename yourself to be anonymous. To request to speak, use the "raise hand" icon by rolling over the bottom of the screen.

To Join by phone: Dial 1-669-900-9128 and enter the meeting ID 963 6174 8103. If you wish to comment during the public comment portion of the agenda, Press *9 and wait to be recognized by the Chair.

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All agenda items are for discussion and possible action

Public Comment Policy: *Members of the public may speak on any items on the Agenda and items not on the Agenda during the initial Public Comment period. Members of the public may also comment on any item listed on the agenda as the item is taken up. Members of the public may not speak more than once on any given item. The Chair may limit public comment to 3 minutes or less.*

AGENDA

7:00pm

1. **Roll Call**
2. **Preliminary Matters**
    a. Action Item: September 23, 2021 Agenda Approval
    b. Public Comment
    c. Action Item: Approval of the July 22, 2021 minutes

Health, Housing & Community Service Department
Mental Health Commission

3. **Housing, Homelessness and people with SMI and SUD in Berkeley Presentation – Kirsten White, RDA, John Cervetto, RDA & Karen Klatt, BMH**

4. **Mental Health Manager's Report and Caseload Statistics - Steve Grolnic-McClurg**
   a. **MH report**
   b. **Berkeley Mental Health Caseload Statistics August**

5. **Specialized Care Unit Steering Committee Update – Dr. Lisa Warhuus**

6. **Re-Imagining Public Safety Task Force Update**

7. **Alternatives to Santa Rita Jail Subcommittee Report**

8. **Whole Person Care – Access to "Community Health Records" and Public Education Campaign**

9. **Prioritize Agenda and Topics for October Meeting**

10. **Adjournment**

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Contact person: Jamie Works-Wright, Mental Health Commission Secretary (510) 981-7721 or Jworks-wright@cityofberkeley.info

Communication Access Information: This meeting is being held in a wheelchair accessible location. To request a disability-related accommodation(s) to participate in the meeting, including auxiliary aids or services, please contact the Disability Services specialist at 981-6418 (V) or 981-6347 (TDD) at least three business days before the meeting date. ***Please refrain from wearing scented***

products to this meeting. Attendees at trainings are reminded that other attendees may be sensitive to various scents, whether natural or manufactured, in products and materials. Please help the City respect these needs. *Thankyou.*

SB 343 Disclaimer

Any writings or documents provided to a majority of the Commission regarding any item on this agenda will be made available for public inspection in the SB 343 Communications Binder located at the Adult Clinic at 1521 University Ave, Berkeley, CA 94703

Department of Health,
Housing & Community Services
Mental Health Commission

Berkeley/Albany Mental Health Commission
Draft Minutes

7:00pm
Zoom Webinar

Regular Meeting
July 22, 2021

Members of the Public Present: Kelly Hammargr, Shirley Posey, Kim Nemirow, Carole Marasovic, Paul Kealoha-Blake, Wendy Alfsen, Andrew Phelps, Tommy Escarcega
Staff Present: Fawn Downs, Karen Klatt, Steven Grolnic McClurg Jamie Works-Wright

1) **Call to Order at 7:04pm**
Commissioners Present: Javonna Blanton, boona cheema, Margaret Fine, Monica Jones, Edward Opton, Andrea Prichett **Absent:** Maria Moore, Terry Taplin

2) **Preliminary Matters**
   a) **Approval of the July 22, 2021 Agenda**
   M/S/C (Cheema, Opton) Motion to move item #10 The U.S. Department of Justice Investigation of Santa Rita Jail Report to item #5.
   PASSED
   Ayes: Blanton, cheema, Fine, Jones, Opton, Prichett, **Noes:** None; **Abstentions:** None; **Absent:** Moore, Taplin

   b) **Public Comment** – 3 Public Comment – Sidewalk ordinance August 1, 2021

   c) **Approval of the June 24, 2021 Minutes**
   M/S/C (Fine, Jones) Make a motion to adopt the June 24, 2021 minutes
   PASSED
   Ayes: Blanton, cheema, Fine, Jones, Opton, Prichett, **Noes:** None; **Abstentions:** None; **Absent:** Moore, Taplin

3. **Mental Health Service Act (MHSA) Annual Report FY 21/22 Presentation and Public Hearing – Karen Klatt**
   PASSED
   M/S/C (Fine, cheema) *Motion to call the question. (To put an end to the debate)
   Ayes: Blanton, cheema, Fine, Jones, **Noes:** Prichett; **Abstentions:** Opton**, Absent:** Moore, Taplin
   M/S/C (Fine, cheema) Motion to approve the MHSA Annual Report FY 21/22 and submit to the Berkeley City Council.
   PASSED

Ayes: Blanton, cheema, Fine, Jones, **Noes:** Prichett; **Abstentions:** Opton**, Absent:** Moore, Taplin

8:57*Motion to extend meeting

M/S/C (Fine, Opton) Make a motion to extend the meeting by 20 minutes
PASSED
Ayes: Blanton, cheema, Fine, Jones, Opton, Prichett, **Noes:** None; **Abstentions:** None; **Absent:** Moore, Taplin

4. **Interview and vote on the nomination of Tommy Escarcega on the Mental Health Commission**
   M/S/C (Fine, Prichett) Make a motion to nominate Tommy Escarcega to join us on the Mental Health Commission
   PASSED
   Ayes: Blanton, cheema, Fine, Jones, Opton, Prichett, **Noes:** None; **Abstentions:** None; **Absent:** Moore, Taplin

5. **U.S. Department of Justice Investigation of Santa Rita Jail Report –**

   M/S/C (Prichett, Opton) Motion for the Santa Rita DOJ Investigation subcommittee with commissioners Opton, cheema and Prichett.
   PASSED
   Ayes: Blanton, cheema, Fine, Jones, Opton, Prichett, **Noes:** None; **Abstentions:** None; **Absent:** Moore, Taplin

6. **Specialized Care unit Update – Dr. Lisa Warhuus – No Motion made**

7. **Reimagining Public Safety Task Force Update – No motion made**

9:19*Motion to extend the meeting by another 5 minutes to 9:25pm
M/S/C (Fine, Prichett)
PASSED
Ayes: Blanton, cheema, Fine, Jones, Opton, Prichett, **Noes:** None; **Abstentions:** None; **Absent:** Moore, Taplin

8. **Discussion re: SCU & Reimagining Public Safety initiative, including how they interface and coordinate – No Motion made**

9. **Public Education Campaign – Did not get to this item**

10. **Mental Health Manager Report and Caseload Statisitics – Steven Grolnic-McClurg**

    M/S/C (Prichett, Opton) Motion for the commission to submit a letter to the City Manager, Deputy City Manager, Mental Health Manager, Steven Grolnic-McClurg, District City Attorney, Director, Lisa Warhuus and City Council about implementing the Community Health Records System and offering a presentation if they are willing to do it.
    PASSED
    Ayes: Blanton, cheema, Fine, Jones, Opton, Prichett, **Noes:** None; **Abstentions:** None; **Absent:** Moore, Taplin

a. Electronic Information available to Division Staff – No motion
b. Demographic information gathered for service users – No motion

11. Request/Prioritize Topics for Mental Health Manager Report and Presentation – Did not get to the item

12. Discussion Topic for Mental Health Manager Report and Presentation – Did not get to this item

13. Prioritize Agenda items for September Meeting – did not get to this item.

14. Adjournment – 9:25pm Meeting ended

Minutes submitted by: _____
Jamie Works-Wright, Commission Secretary

Berkeley Innovation Project Plan

Encampment-based Mobile Wellness Center

Berkeley Mental Health Division

June 2021

RDA CONSULTING

Table of Contents

City Name: City of Berkeley

Date Submitted: XX-XX-XXXX

Project Title: Encampment-based mobile wellness center for Berkeley's unhoused community members

Total Amount Requested: $2,802,400

Project Duration: 5 years

Summary Statement: Pilot an encampment-based mobile wellness center that offers a menu of activities (i.e. social, clinical, as well as personal care and hygiene services) and is staffed by a team of peers that can offer culturally-specific services, including individuals from the encampment community.

Section 1: Innovation Requirement Categories

General Requirement:

An Innovative Project must be defined by one of the following general criteria. The proposed project:

- ☐ Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention
- ☒ Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
- ☐ Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system
- ☐ Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite

Primary Purpose:

An Innovative Project must have a primary purpose that is developed and evaluated in relation to the chosen general requirement. The proposed project:

- ☐ Increases access to mental health services to underserved groups
- ☐ Increases the quality of mental health services, including measured outcomes
- ☒ Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes
- ☐ Increases access to mental health services, including but not limited to, services provided through permanent supportive housing

Section 2: Project Overview

Primary Problem

What primary problem or challenge are you trying to address? Please provide a brief narrative summary of the challenge or problem that you have identified and why it is important to solve for your community. Describe what led to the development of the idea for your INN project and the reasons that you have prioritized this project over alternative challenges identified in your county.

Approximately 1,100 unhoused individuals live in Berkeley, including both sheltered and unsheltered environments.[1] This represents 1% of Berkeley's total population. Not only is homelessness prevalent in Berkeley, most of the time it is also long-term: of the 1,100, 64% reported that their current episode of homelessness has lasted one year or more. Across the three most recent citywide point-in-time counts (2015-2019), unhoused Berkeley residents consistently identify supportive services, such as benefits/income assistance, rental assistance, or mental health services, as interventions that may have prevented homelessness. This qualitative data indicates gaps in service accessibility, availability, and/or awareness when homelessness prevention is still possible. Moreover, as much as supportive services are needed upstream before homelessness occurs, they grow even more vital when an individual or family becomes unhoused. In recent years, including throughout the six-monthlong community input process that resulted in this project proposal, Berkeley residents consistently name homeless services as a top citywide priority.

Though both direct and supportive services for the homeless population are urgently needed and increasingly funded, take-up among unhoused community members in Berkeley remains low for certain services, particularly mental health services. Currently, Berkeley Mental Health (BMH) serves approximately 360 unhoused individuals each year through its Homeless and Outreach Treatment Team (HOTT) program.[2,3] The majority of HOTT service encounters are one- to two-time touches and do not result in ongoing services. Successfully linking unhoused individuals to mental health services remains a salient challenge, particularly for those who have never connected to services. To address this challenge, the following project description proposes an innovation at the nexus of **service provision** (by focusing on services that unhoused community members define as supportive of mental health), **service location** (by bringing services onsite to encampments in Berkeley), and **service providers** (by employing individuals with lived or adjacent experience to homelessness, including individuals from the encampment community itself).

Proposed Project: Encampment-based Mobile Wellness Center

Describe the INN Project you are proposing. Include sufficient details that ensures the identified problem and potential solutions are clear. In this section, you may wish to identify how you plan to implement the project, the relevant participants/roles within the project, what participants will typically experience, and any other key activities associated with development and implementation.

For its Innovation project, BMH is proposing an encampment-based mobile wellness center that would provide a menu of customizable services to Berkeley's unhoused population. The proposed project was developed using input obtained from community members with lived or adjacent experiences of homelessness during BMH's community program planning (CPP) process. Through in-person and online

[1] https://everyonehome.org/wp-content/uploads/2019/09/2019HIRDReport_Berkeley_2019-Final.pdf
[2] Berkeley Mental Health Department Homeless and Outreach Treatment Team (HOTT) Evaluation. RDA Consulting, July 2020.
[3] Source data includes 734 service encounters between January 2018 and February 2020.

surveys, 1:1 interviews and virtual community meetings, BMH collected robust input during the CPP process.

The proposed project adapts existing homeless outreach practices by operationalizing community input in the following ways:

- **Service Provision:** Rather than operating on a blanket assumption that clinical and/or psychiatric services should be prioritized, the wellness center project focuses on services explicitly identified by unhoused community members as most supportive of mental wellness.
- **Service Location:** The wellness center will be a mobile service center stationed at homeless encampments in Berkeley. By hosting services onsite at encampments, outreach transforms from outside-in to inside-out, from sporadic to ongoing, and from disconnected to integrated.
- **Service Providers:** Wellness center staff, including the program manager and peer providers, will include individuals with lived or adjacent experience of homelessness and/or recovery. In addition, the wellness center program will use funds to compensate individuals from the encampment to connect consumers to services, incentivize participation among existing and potential consumers, and engage in day-to-day program planning and operations.

While many homeless outreach and/or mobile engagement programs employ peers, and others co-locate services with other agency (i.e. educational) or institutional (i.e. correctional) providers, no program adapts homeless outreach services in the above ways.

As the wellness center will not explicitly focus on clinical and/or psychiatric services, the project does not aim to directly increase access to traditional mental health services, nor the quality of traditional mental health service provision. Rather, it aims to leverage collaboration with unhoused community members to promote mental health outcomes for the target population, which may include increases in service referrals, service linkages, and engagement of mental health services. Figure 1 below summaries key components of the project proposal.

Figure 1. Key Components of Proposed Wellness Center Project

Wellness Center Service Provision

"It's not a psychiatrist they need, it's not a behavioral modification they need; what they need is the basics of life – the ability to eat, wash themselves, read a book, meditate, drink water, take a walk, be around the people who you want to be around, go to the library. If those things were guaranteed, it would support mental health and head off the cases where people develop more deeply entrenched conditions, where they start evidencing behaviors that people assume are intrinsic – not realizing [these behaviors] are from all the times when they don't know where they will be eating, will they have to eat out of a trash can, if when they sleep will someone kick them in the head."

- Berkeley community member with lived experience of homelessness

The encampment-based wellness center will deliver onsite services to members of the Berkeley community who are unhoused. Proposed services are informed directly from community input, including input from community members with lived experiences of homelessness during the CPP process. While some of this input did call for outreach that included therapeutic services, a lot of the input called for supportive services more generally.

	Food & Hygiene Services	Benefits Enrollment & Service Navigation	Trauma-Informed Wellness Services	Enrichment & Community Services
Proposed Service Areas	- Mobile showers - Hand-washing - Laundry tokens and/or laundry services - Snacks, water - Toiletries & personal hygiene products	- Benefits enrollment (i.e. Medi-Cal, Medicaid, veterans' services, HUD) - Appointment reminders - Transit assistance	- Medication counseling - Meditation & mindfulness - Massage therapy - Music therapy - Stress management counseling - Peer-led wellness services	- Day storage - Community enrichment events - Movement & exercise classes - Guided walks and nature-based enrichment - Community library
Service Estimates	*BMH estimates that up to **500 individuals** will receive food/hygiene services each year, with **5-10%** connecting to outside mental health services via this service area.*	*BMH estimates that up to **150 individuals** will receive benefits/ navigation services each year, with **5-10%** connecting to outside mental health services via this service area.*	*BMH estimates that up to **150 individuals** will receive wellness services each year, with **5-10%** connecting to outside mental health services via this service area.*	*BMH estimates that up to **150 individuals** will receive enrichment services each year, with **5-10%** connecting to outside mental health services via this service area.*

lists the wellness center's proposed service areas:

Table 1. Proposed Service Areas & Service Participants

	Food & Hygiene Services	Benefits Enrollment & Service Navigation	Trauma-Informed Wellness Services	Enrichment & Community Services
Proposed Service Areas	- Mobile showers - Hand-washing - Laundry tokens and/or laundry services - Snacks, water - Toiletries & personal hygiene products	- Benefits enrollment (i.e. Medi-Cal, Medicaid, veterans' services, HUD) - Appointment reminders - Transit assistance	- Medication counseling - Meditation & mindfulness - Massage therapy - Music therapy - Stress management counseling - Peer-led wellness services	- Day storage - Community enrichment events - Movement & exercise classes - Guided walks and nature-based enrichment - Community library
Service Estimates	*BMH estimates that up to **500 individuals** will receive food/hygiene services each year, with **5-10%** connecting to outside mental health services via this service area.*	*BMH estimates that up to **150 individuals** will receive benefits/ navigation services each year, with **5-10%** connecting to outside mental health services via this service area.*	*BMH estimates that up to **150 individuals** will receive wellness services each year, with **5-10%** connecting to outside mental health services via this service area.*	*BMH estimates that up to **150 individuals** will receive enrichment services each year, with **5-10%** connecting to outside mental health services via this service area.*

Many of the above food, hygiene, and navigation services are comparable to those commonly provided by homeless outreach treatment teams and/or mobile engagement teams. However, in the mobile wellness center environment, service provision will be directed by the changing needs of the community, with week-to-week service provision being planned via ongoing conversations with members of the encampment community. For example, while psychiatric and/or therapeutic services are not listed above due to both low take-up of these services among members of the unhoused population in Berkeley historically and a minority of community input requesting these services, community needs may shift, and wellness center staff will adapt service provision as needed. The customizable nature of service provision will be made possible through the provider itself, which will be a local organization with deep expertise across proposed service areas.

Target Population. BMH estimates that the wellness center will serve up to 500 unique individuals each year, or roughly 50% of Berkeley's current unhoused population. This estimate is based on annual service data from organizations providing outreach services to the unhoused population in Berkeley. The service estimates vary among service areas, as food/supplies represent a majority of services currently provided, compared to case management or other services. For this reason, the above estimates use the best available data, but still may be an overcount of food/hygiene services and an undercount of other service areas.

BMH expects that individuals served by the wellness center will in large part reflect the demographics of the unhoused population in Berkeley. As described by the most recent point-in-time count conducted in 2019, the target population is predominantly male (66%), non-Hispanic/Latinx (88%), Black/African

American (57%), single (vs. families), and does not identify as LGBTQ+ (86%). Around half (48%) of the target population is local and has lived in the community for 10 years or more.

The target population also has significant medical needs: 41% reported a disabling health condition, with 28% reporting chronic health problems. Just under one-half (42%) reported a psychiatric or emotional condition, 32% reported a substance use disorder, and 31% reported PTSD. The proposed design of the wellness center is responsive to these needs in regards to both the *types* of services provided as well as *how* those services are delivered.

Wellness Center Service Location

When the plan was initially developed, the City was planning to have a sanctioned encampment, and has since determined it could not find a place for one, so the plan is to have a Wellness Center going to multiple sites where there are encampments. This means that it can provide onsite services where needed, can move where and if the community it is serving changes locations, but will have a consistent, visible presence at encampments.

The location of the proposed wellness center is one way in which it is intended to feel a part of the community it is serving. The other way this project aims to deliver services from the inside-out rather than the outside-in is by bringing peers and individuals with lived experience, including individuals residing in the encampment, onboard the wellness center team.

Wellness Center Service Providers

A key innovation of this project is that it will recruit and hire peers, or individuals with lived or adjacent experiences of homelessness, to staff the wellness center. In addition, the wellness center will compensate individuals who live in the encampment community to support wellness center services in a separate capacity.

Broadly, the staff team will consist of a program director, program manager, onsite peer providers, and onsite wellness ambassadors. The **wellness ambassadors** will be individuals who live in the encampment communities. This role, designed using the Community Health Worker model as defined by the California Healthcare Foundation, will be a stipend-based, part-time position with the following core competencies and key duties:[4]

- **Cultural Competency.** Acting as a liaison between the encampment community and the wellness center, wellness ambassadors should represent and be able to communicate the needs of the encampment community. Their input and feedback should inform ongoing process and program improvements as part of the wellness center project.
- **Information & Resource-Sharing.** Care for and support consumers by doing things such as sharing information regarding resources, documenting daily wellness center and service-specific utilization, and supporting the care and education provided by wellness center staff.
- **Social Supports.** Provide social support by being available to listen and talk through problems that consumers are experiencing, and referring them to the appropriate wellness center staff member(s). Onsite referrals from wellness ambassadors are meant to facilitate introductions and trust-building with wellness center staff.
- **Self-Care Coaching.** Educate consumers about self-care and helping them learn self-care skills.

[4] California Healthcare Foundation. "Building peer support programs to manage chronic disease: seven models for success." Published Dec 2006. https://www.chcf.org/wp-content/uploads/2017/12/PDF-BuildingPeerSupportPrograms.pdf

The service provider will provide cohort-based training to the wellness ambassadors to support them in their work at the wellness center. Wellness ambassadors will receive stipends for a six-month period, with the opportunity to extend to a year.

Full-time, onsite **peer providers** will coordinate and deliver wellness center services. Peer providers will be trained in trauma-informed best practices for service delivery. Peer providers will have the following key duties, informed by best practices set by the National Health Care for the Homeless Council:[5]

- **Outreach/Enrollment.** Assist with enrollment into housing, nutrition, and health insurance programs and entitlements; provide culturally competent enrollment, health education, and outreach services; conduct motivational interviewing and rapport building with potential clients using empowering language and taking the lead from the client; offer friendly and helpful advice based on problems and concerns identified by the client; offer day-to-day survival tips and kits such as first aid, clothing, water, hand sanitizer, etc.
- **Navigation.** Help clients fill out and file paperwork for Medicaid, Medicare, Veterans Services, HUD, local housing authority, HCH clinic, prescription coverage, and any other services; follow-up and track individuals experiencing homelessness and/or recently housed; schedule and remind clients of appointments and provide transportation if necessary; facilitate client empowerment to fully engage with all members of their health care team; accompany consumers on medical visits as a source of support; help consumers access needed supports for transitions such as attaining housing.
- **Advocacy/Education.** Develop and utilize connections with community service representatives to help clients get what they need; work with wellness ambassadors to update provider teams about what issues consumers are facing; collaborate with wellness ambassadors in program planning for the wellness center.

Finally, a **community of practice** comprised of program staff, consumers, community advocates, and city leaders will meet quarterly to create a learning space to exchange insights and tackle challenges related to the wellness center project. This community of practice may take the form of a formal advisory group or an informal relationship-building space. Following project approval and during the initial project development phase, the provider will work with stakeholders and community members, including unhoused Berkeley residents and homeless outreach staff, to collect input on how they would feel best supported by the community of practice.

Research on Proposed Innovation Project

Describe the efforts made to investigate existing models or approaches close to what you're proposing. Have you identified gaps in the literature or existing practice that your project would seek to address? Please provide citations and links to where you have gathered this information.

Wellness Centers. Many homeless-serving agencies and community-based organizations in local jurisdictions have implemented wellness centers to deliver a multitude of services. Some localities, such as Victorville in San Bernardino County, are developing multi-acreage wellness center campuses that will offer medical, recreational, and supportive services to individuals experiencing homelessness.[6] Wellness center campuses are innovative, complex projects with high start-up and operational costs, with service

[5] Community Health Workers in Health Care for the Homeless: A Guide for Administrators. National Health Care for the Homeless Council, June 2011. https://nhchc.org/

[6] https://www.victorvilleca.gov/services/homeless-outreach/homeless-land-page/city-iniatives/wellness-recuperative-care-center

delivery occurring in a brick-and-mortar location. Other cities, such as Los Angeles, provide multiple smaller wellness centers as service access points for the unhoused population.[7]

These examples of brick-and-mortar wellness centers largely operate during weekday business hours, and none of them are located within at an encampment itself (although Los Angeles does have centers adjacent to Skid Row). BMH seeks to further innovate on the existing brick-and-mortar wellness center model by proposing a smaller-scale, mobile model that is able to go to multiple encampments.

Mobile Approaches in Healthcare for the Homeless. Generally, mobile models used in healthcare for the homeless (HCH) programs are limited to mobile health clinics, and BMH did not identify current or ongoing examples of mobile wellness centers that are co-located with existing encampments. Mobile health clinics embedded within a local or regional HCH service landscape, on the other hand, are increasingly common and well-researched, with thousands of active mobile health clinics nationwide.[8] One such example is WeHOPE in East Palo Alto, which has a fleet of vehicles delivering mobile homeless services, including onsite hygiene services.[9] The learning goals described in the following section are adapted in part from outcomes often seen in mobile health clinics. In this way, BMH looks to build on emergent learnings from the mobile HCH service landscape.

Peer-led Service Delivery. Integrating peer-led service delivery into mental health, substance use disorder, or homeless outreach programs is an emergent best practice across the HCH service landscape. Peer providers may already be credentialed, or the hiring organization may provide training as part of onboarding or ongoing professional development. In other cases, peers may not receive extensive formal training, or they may be volunteers. Regardless of the specifics of the position or training, a growing body of evidence suggests that the non-hierarchical, reciprocal relationship created between a peer provider and a consumer leads to better health outcomes for the latter.[10]

Wellness centers may be staffed by peers, such as the RAMS Inc. Peer Wellness Center in San Francisco.[11] These wellness centers provide many of the same services that BMH is proposing to include in its wellness center. However, though many peer-staffed wellness centers do provide targeted services for people experiencing homelessness, BMH could not find examples of peer teams that formally include individuals from encampment communities on staff.

Learning Goals

What is it that you want to learn or better understand over the course of the INN Project? How do your learning goals relate to the key elements/approaches that are new, changed or adapted in your project?

This project proposes innovations related to the method (peer- and community member-led) and location (encampment-based) of HCH service delivery. The following learning goals reflect what the project seeks to better understand in terms of the potential impacts of these innovations on consumer outcomes: Does providing wellness services onsite, in an encampment environment, make a difference in terms of consumers' self-reported overall health and mental health, and their take-up of other health and mental

[7] https://www.thepeopleconcern.org/homeless-services/
[8] Yu, Stephanie W Y et al. "The scope and impact of mobile health clinics in the United States: a literature review." International journal for equity in health vol. 16,1 178. Published Oct 2017. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5629787/
[9] https://www.wehope.org/mobile
[10] California Healthcare Foundation. "Building peer support programs to manage chronic disease: seven models for success." Published Dec 2006. https://www.chcf.org/wp-content/uploads/2017/12/PDF-BuildingPeerSupportPrograms.pdf
[11] https://ramsinc.org/peer-based/

health services? Does it matter that individuals from the encampment community are brought on-board and compensated to help deliver these services?

These questions are captured in the learning goals in Table 2Table 1 below. Target outcomes are listed for each learning goal, as well as the data that will be collected to measure progress toward these outcomes. While the specific data collection modalities may change, particularly as service providers transition from virtual back to in-person services, the survey and other tools listed are exemplars intended to reflect the key outcomes supporting each learning goal.

Table 2. Proposed Project Learning Goals

	LG 1. Do onsite wellness center services have an impact on consumers' overall and/or mental health?	**LG 2. Do onsite wellness center services increase take-up of mental health services more broadly among consumers?**	**LG 3. How does having individuals from the community help provide services shape delivery, including satisfaction with services?**
What do we want to learn?	#/% self-reported changes in overall health (+/-) #/% self-reported changes in mental health (+/-)	***New referrals:*** # of new service referrals #/% linkages to services #/% service engagement ***Existing referrals:*** Δ in service engagement for wellness center consumers with prior service referrals	% satisfaction with wellness center services #/% new vs. returning consumers #/% of consumers recruited to wellness center services via ambassadors Δ in service take-up between wellness center consumers & baseline service take-up
How will we learn it?	✓ **Pre/post surveys** measuring consumers' self-reported overall health and mental health ✓ **Focus groups** with wellness center consumers ✓ **Onsite observations** at wellness center location	✓ **Interviews** with wellness center consumers ✓ **Interviews** with wellness center staff ✓ **Interviews** with community-based service providers ✓ Program-level **service referral/linkage data**	✓ **Focus groups** with wellness center consumers ✓ **Focus groups** with wellness center ambassadors ✓ **Pre/post satisfaction surveys** for wellness center consumers ✓ **Onsite observations** at wellness center location

These learning goals, along with the proposed key outcomes and data collection modalities, reflect the intention of the project evaluation to include robust and meaningful stakeholder participation.

Section 3: Regulatory Requirements

Contracting

If you expect to contract out the INN project and/or project evaluation, what project resources will be applied to managing the County's relationship to the contractor(s)? How will the County ensure quality as well as regulatory compliance in these contracted relationships?

BMH will follow all City of Berkeley contracting procedures to implement a Request for Proposal process and execute a contract with the chosen vendor. MHSA staff will monitor the contractor performance to ensure quality and regulatory compliance.

Community Program Planning

Please describe the County's Community Program Planning process for the Innovative Project, encompassing inclusion of stakeholders, representatives of unserved or under-served populations, and individuals who reflect the cultural, ethnic and racial diversity of the County's community.

BMH conducted a series of virtual community outreach events during October – February, 2020-21 to meet Community Program Planning (CPP) requirements as part of its MHSA Innovation project development process.

With a core objective of identifying a project to support the mental health needs of unhoused community members, BMH implemented a two-tiered CPP process: first, BMH solicited feedback from individuals with lived experience as well as from community members more broadly; then, BMH engaged providers and advocates working in mental health and homelessness to review and further iterate community input.

As part of the initial CPP process, BMH conducted the following community outreach activities:

- **1:1 phone interviews with individuals with lived experiences of homelessness**;
- **Paper surveys**, administered by outreach staff, **for individuals with lived experience of homelessness** who were unable to complete an interview;
- **Virtual town hall**, open to all Berkeley community members;
- **Online community survey**, open to all Berkeley community members;

Subsequent to this series of community engagement activities, BMH facilitated multiple working sessions with local homeless outreach providers and advocates. The quality data from the initial CPP activities, together with the perspectives of local stakeholders with expertise in housing and homelessness, yielded a rich set of prospective project proposals. Additional internal review by BMH staff and city leadership further defined the INN project proposal.

MHSA General Standards

Using specific examples, briefly describe how your INN Project reflects, and is consistent with, all potentially applicable MHSA General Standards listed below. If one or more general standards could not be applied to your INN Project, please explain why.

- **Community Collaboration.** This project was informed by an extensive community collaboration process. The final project idea was generated directly as a result of the two-tiered CPP process described above.
- **Cultural Competency.** The CPP process centered the perspectives of individuals with lived experiences of homelessness. A result of this is the main framing of this project; namely, that is does not purport to offer explicitly clinical interventions at an encampment site. Community members with lived experience shared nuanced perspectives, many of which called for more accessible opportunities for wellness opportunities and social interaction more holistically. This is what the wellness center proposes – to make services immediately accessible, and to make the center a "generalist" health/wellness endeavor, with a customizable menu of service offerings. Moreover, ongoing program planning will be informed via collaboration between the provider team and unhoused community members, ensuring the services remain relevant and retain cultural competency.

- **Client & Family-Driven.** Both phases of the CPP process included perspectives from individuals with lived or adjacent experiences of homelessness. These perspectives drove the project planning process and defined the wellness center as a viable project option. Moving from project planning to implementation, the wellness center will remain client-driven because consumer input, and input from wellness ambassadors, will inform program planning and service delivery.
- **Wellness, Recovery, and Resilience-Focused.** The proposed project is responsive to the tenets of wellness, recovery, and resiliency. In particular, the learning goals reflect a commitment to long-term monitoring and evaluation of consumer outcomes related to mental health and wellness, as well as service engagement rates (including for recovery services, mental and behavioral health services, and medical services). Moreover, one of the key ways in which the project aims to support consumer outcomes is by operating as a consumer-led initiative.
- **Integrated Service Experience for Clients and Families.** The encampment-based wellness center will effectively function as a possible entry-point to more specialized services, whether through onsite specialty service providers or via service referrals. This framework means that clients will have the opportunity to access a variety of services coordinated by or in tandem with the wellness center.

Project Sustainability

Briefly describe how the County will decide whether it will continue with the INN project in its entirety, or keep particular elements of the INN project without utilizing INN Funds following project completion.

Through the local evaluation process, community of practice meetings, and conversations with stakeholders and city leadership, BMH will regularly evaluate the wellness center project to ensure that the components that are successful, or the entire project, can continue. Funding for continuation could come from a variety of sources: City General Funds, MHSA funds, and/or existing special taxes in Berkeley that fund homeless services.

Communication & Dissemination Plan

Describe how you plan to communicate results, newly demonstrated successful practices, and lessons learned from your INN Project. Please list up to 5 keywords or phrases for this project that someone interested in your project might use to find it in a search.

To support community-wide dissemination of project information and lessons learned, BMH will engage stakeholders via online public forums as well as virtual and in-person community meetings. These venues have successfully been used with previous MHSA Innovation projects, and feedback from stakeholders during the CPP process supporting this project largely reflected that community members appreciate diverse opportunities for input and discussion.

If a member of the community is interested in learning more about the project, they can use the following keywords in an Internet search:

- **Keywords:** City of Berkeley MHSA, Berkeley mental health projects, Berkeley wellness center, Berkeley encampment wellness center

Timeline

Specify the expected start date and end date of your INN Project, the total timeframe (duration) of the project, and include a project timeline that specifies key activities, milestones, and deliverables—by quarter.

Program Year (FY 2021-22 thru FY 2025-26)	*2021*	*2022*				*2023*				*2024*				*2025*				*2026*			
Quarter		*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*11*	*12*	*13*	*14*	*15*	*16*	*17*	*18*	*19*	*20*
Phase 1. Project Launch																					
1.1 RFP & Contract Execution, Service Provider																					
1.2 RFP & Contract Execution, Local Evaluator																					
1.3 Launch Community of Practice																					
1.4 Community Outreach & Project Marketing																					
1.5 Launch Wellness Ambassador Program																					
Phase 2. Wellness Center Implementation																					
2.1 Community of Practice Quarterly Meeting																					
2.2 Wellness Ambassador Cohort Onboarding																					
2.3 Wellness Center Peer Provider Training																					
Phase 3. Local INN Project Evaluation																					
3.1 Evaluation Plan Finalization																					
3.2 Data Collection Tool Development																					
3.3 Baseline (Pre) Data Collection																					
3.4 Interim Data Collection																					
3.5 Interim Evaluation Reporting																					
3.6 Final (Post) Data Collection																					
3.7 Evaluation Report Development																					
3.8 Evaluation Report Finalization & Dissemination																					
Phase 4. Sustainability Planning																					
4.1 Sustainability Planning Meetings																					
4.2 Continuation Funding Planning																					
4.3 Dissemination of Project Continuation Decisions																					
Phase 5. Project Close																					
5.1 INN Funding Close-out																					

Section 4: INN Project Budget & Source of Expenditures

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*							
EXPENDITURES							
PERSONNEL COSTS (salaries, wages, benefits)		**FY 21-22**	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	**TOTAL**
1.	Salaries (.1 x PD, 1 x PM, 3 x peer providers)	197,500	395,000	395,000	395,000	395,000	1,777,500
2.	Direct Costs (staff training)	10,000	5,000	5,000	5,000	5,000	30,000
3.	Indirect Costs (admin overhead @ 5%)	10,400	20,000	20,000	20,000	20,000	90,400
4.	Total Personnel Costs	217,900	420,000	420,000	420,000	420,000	1,897,900
OPERATING COSTS		**FY 21-22**	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	**TOTAL**
5.	Direct Costs (wellness ambassador stipends)	46,100	92,200	92,200	92,200	92,200	414,900
6.	Direct Costs (programming)	6,000	12,000	12,000	12,000	12,000	54,000
7.	Indirect Costs (admin overhead @ 5%)	2,600	5,200	5,200	5,200	5,200	23,400
8.	Total Operating Costs	54,700	109,400	109,400	109,400	109,400	492,300
NON RECURRING COSTS (equipment, technology)		**FY 21-22**	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	**TOTAL**
9.	Wellness center equipment (trailer, truck, customization)	220,000	-	-	-	-	220,000
10.	Wellness center technology (staff phones, laptops/tablets)	3,000	-	-	-	-	3,000
11.	Marketing	16,000	-	-	-	-	16,000
12.	Total Non-recurring costs	239,000	-				239,000
CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)		**FY 21-22**	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	**TOTAL**
13.	Direct Costs	15,000	35,000	35,000	35,000	45,000	165,000
14.	Indirect Costs (admin overhead @ 5%)	750	1,750	1,750	1,750	2,200	8,200
15.	Total Consultant Costs	15,750	36,750	36,750	36,750	47,200	173,200
OTHER EXPENDITURES (please explain in budget narrative)		**FY 21-22**	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	**TOTAL**
16.							
17.							
18.	Total Other Expenditures						
BUDGET TOTALS		**FY 21-22**	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	
Personnel (line 1)		197,500	395,000	395,000	395,000	395,000	1,777,500
Direct Costs (add lines 2, 5 and 11 from above)		77,100	144,200	144,200	144,200	154,200	663,900
Indirect Costs (add lines 3, 6 and 12 from above)		13,750	26,950	26,950	26,950	27,400	122,000
Non-recurring costs (line 10)		239,000	-	-	-	-	239,000
Other Expenditures (line 16)		-	-	-	-	-	-

TOTAL INNOVATION BUDGET	527,350	566,150	566,150	566,150	576,600	2,802,400

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)							
ADMINISTRATION:							
A.	**Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 21-22**	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	**TOTAL**
1.	Innovative MHSA Funds	511,600	529,400	529,400	529,400	529,400	2,629,200
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Administration**						
EVALUATION:							
B.	**Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 21-22**	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	**TOTAL**
1.	Innovative MHSA Funds	15,750	36,750	36,750	36,750	47,200	173,200
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Evaluation**						
TOTAL:							
C.	**Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:**	**FY 21-22**	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	**TOTAL**
1.	Innovative MHSA Funds	527,350	566,150	566,150	566,150	576,600	2,802,400
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Expenditures**	**527,350**	**566,150**	**566,150**	**566,150**	**576,600**	**2,802,400**
*If "Other funding" is included, please explain.							

City of Berkeley MHSA INN CPP Process: Summary of Community Input

CPP Process Overview

The City of Berkeley (Berkeley) conducted virtual community outreach in the fall of 2020 to meet Community Program Planning (CPP) requirements as part of its MHSA Innovation project development process. As part of its CPP process to identify a project that would best support the mental health needs of community members experiencing homelessness, Berkeley conducted the following community outreach activities:

- 1:1 phone interviews with individuals experiencing homelessness
- Survey for individuals experiencing homelessness & unable to complete interview
- Virtual Town Hall
- Online Community Survey

Community Input Summary

The following are summary-level themes from each of the four modes of community outreach conducted as part of Berkeley's CPP process for its MHSA Innovation project development cycle.

Input from Community Members Experiencing Homelessness (Interviews)

Individuals experiencing homelessness who completed an interview identified the following mental health needs and service barriers:

What are your biggest mental health needs?	What has worked in supporting your mental health?	What additional services do you need?	What makes it difficult to support your mental health?
- Ability to get enough sleep: "Chronic lack of rest exacerbates issues people living on the street face." - Stable, safe housing - Access to basic needs, e.g. water, bathrooms, toilet paper - Resources to deal with chronic pain	- Meditation - Socializing to promote community - Org in Berkeley that would provide foot washing, hair-cuts, food, clothing, doctor referrals - Berkeley Drop-in Center, Dorothy Day Center, Pacific Center - "Libraries are lifesaving": offer privacy, quiet, bathrooms, and	- "A safe place with people that look like me who are Black and brown." - Services specialized to meet individual needs (e.g. SMI, SUD, former foster youth) - More services with flexible hours - Place to store belongings - Day storage - Ability to transfer from permanent	- Predatory aspect to shelters. Shelters are "not conducive to people getting their lives together." - Racism - Crowding folks at Berkeley locations to meet COVID-19 SIP requirements - Assumption that people experiencing homelessness want to live in an apartment or pay

	ability to charge phone.	or long-term shelter to one-bedroom or SLO	rent as their first next step - Shelter on Dwight with curfews

Input from Community Members Experiencing Homelessness (Survey)

Individuals experiencing homelessness who completed a survey identified the following mental health needs and service barriers:

What are your biggest mental health needs?	What has worked in supporting your mental health?	What additional services do you need?	What barriers make it difficult to meet your mental health needs?
- Medications for seizures - Rest and relaxation - Outreach teams. "My mental health is being managed by LifeLong. We could use more outreach, especially for people with mental health issues that display violence and harm to others which creates a lot of stress." - Showers and affordable place to live. - Mental health, dealing with anger - Self-care - Someone to talk to - Therapy or clinical care - Housing - PTSD - Medicine - Employment - Social help and spending time with friends - Housing - Housing	- Walking, riding bikes - Music, my phone, work - Rock hunting - Being with friends. - Being dry in the rain. - "Peace and quiet. I hide in a broken-down truck, etc. There are not services for non-violent, non-social people." - Gardening, walking, caring for neighborhood animals, coloring, having a safe place to meet with neighbors and be able to leave our RVs or tents. - Consistency with medication - Swimming and walking - Talking to counselor - Making music - Music - Community self-care and exercise - Dancing and singing - Housing	- Transportation - Transportation, help remembering appointments and dates. - Transportation to and from care providers - "Services for all races in the community." - Counselor - Doctor appointments - Food, shelter, clothing - Meds - Open health care clinic - Shelter and job. - Housing - Housing, therapy and rehabilitation. - More marketing and promotion of services and resources - Housing, including emergency housing - Healthy food - Self-care education	- Lack of knowledge of programs available. - "Locks for my bicycle, hot water, proper nutrition." - Society, discrimination, social anxiety, bad memory. - Inconsistency in checking-in and making sure needs are met. - Miscommunication and delivery of medication. - Money - Access to meds and caregivers - Community difficulties - Finding a counselor - No housing - Lack of services - "Lack of tech. Bring back AC Transit!" - Housing - Language - Lack of specialized outreach - Hours – mental health is an

- Stress reduction - Stress management - Proper therapy	- Solitude and rocks - Working out, good sleep/quiet and healthy diet. - Music and playing the piano, harmonica, organ and the harp. - Job - Relaxing - Therapy, proper medication and sufficient housing. - Dorothy Day House and other homeless supports. *Resources or Services:* - BMH HOTT - Free Clinic - LifeLong - Berkeley Mental Health Clinic - BRBC - Shower facilities - Emergency shelter - Options Recovery - Church - Homeless Action Center - BACS	- Make the process of finding a counselor easier. - Housing - More Spanish-speaking services. - "Make it so people don't have to be so sick first before they get help." - Flexible services hours, more availability	around-the-clock need.

Survey respondents also spoke to the ways in which they have been impacted by COVID-19:

- It's harder to survive.
- It is more challenging to get food, water, showers, laundry, and also having access to COVID screenings. I myself have had some signs of anxiety, depression/confusion.
- No way to make money.
- I'm very isolated from my social network.
- Hard to find shower and power and WiFi
- Financial hardship
- Lost my job
- Most the free meals now have no or lousy vegetarian options.
- I am more liable to infection.
- I am now homeless.

Virtual Town Hall

Community members participating in the virtual Town Hall identified the following as pressing mental health needs and service barriers for individuals experiencing homelessness:

What are the biggest mental health needs?	What would make the biggest difference?	What existing services can be leveraged?	What are the biggest barriers?
- Therapy - Reduced police presence - Peer-led services - Cash aid - Transitional housing - Specialized outreach - Rest areas and/or rest beds - Access to mental health resources and accurate diagnoses - Transitional mental health services - Encampment-based services, e.g. therapy or psychiatric services - Aftercare - Consistent case management	- Effective outreach/new HOTT - Tiny homes - Onsite services in encampments - Stronger peer resources and services - Culturally sensitive services, e.g. identity-based therapy groups - Transitional mental health services - More mobile crises teams - Storage for personal belongings - Opportunities for yoga and meditation - Wilderness therapy - Harm reduction teams - App that can link folks to teletherapy or suicide hotlines - Online tools monitor feelings and suicidal thoughts - Restorative justice - Replacing police with peace ambassadors - More flexible service hours - Support for obtaining IDs and documentation	***Partner with:*** - Unhoused people to lead outreach efforts - Suitcase Clinic in Berkeley - Friends on Wheels - Peer-led programs - First They Came for the Homeless encampment - Housing is Health - Bonita House - LifeLong - BACS - Berkeley Free Clinic ***Leverage:*** - Emotion Gym or other online CBT and/or therapeutic tools - Available commercial or community space - Successful case management and housing navigation models, e.g. LifeLong	- Police harassment of houseless people - Forcible removal of encampments - Unsafe shelter environments, particularly for youth, women and gender non-conforming individuals - Lack of awareness of available resources - Lack of culturally sensitive services - Language barriers, particularly for Spanish monolingual community - Limited service hours - Housing folks without supportive or wraparound services

Online Community Survey

Community members providing input via the Berkeley Considers online forum identified the following as pressing mental health needs and service barriers for individuals experiencing homelessness (due to survey response volume, in some cases responses were categorized by theme):

What are the biggest mental health needs?	What would make the biggest difference?	What existing services can be leveraged?	What are the biggest barriers?
- Permanent stable housing bundled with services and medical care - SUD programs - Access to food, showers, technology and safe storing of personal items - Connection - Alternative to police - Coordination of care across service jurisdictions - Safety and security - More caseworkers - Hygiene services - Wraparound services	- Onsite housing, e.g. install micro units - Housing paired with services - Mental health care and treatment - Mobile Care, e.g. needle exchange, food delivery, garbage collection - Mobile hygiene, e.g. shower and laundry trucks - Onsite de-escalation mediators in encampments - Expanded hours for Mobile Mental Health Unit - Mobile therapy van - Targeted outreach, e.g. assign outreach to specific areas, set up Help Tents in each encampment - Pilot an "enriched encampment," with onsite staff and services - Hire diverse group of formerly unhoused people to conduct outreach - Conservatorship - Increase postering to promote services - Cash aid program	***Partner with:*** - Berkeley Free Clinic and community health providers to set aside beds for those in crisis - Property developers or contractors for supportive housing - Social worker trainees at UC Berkeley - UCSF to bring Margot Kushel's programs to East Bay - Consider the Homeless - Food Not Bombs - Friends of Adeline - Friends Outside - Lifelong Street Outreach - Options Recovery - VA Oakland Clinic - Waterside Workshops - Wright Institute - Youth Spirit Artworks ***Replicate:*** - Lunch On Me model used in LA's Skid Row	- Harassment from police/fear of being harmed by police - Resistance to receiving services - Lack of address - Inaccessible service locations - Cost of services - Not enough services - Lack of psychiatric providers - Waiting lists for treatment services - Completing forms in person and on-line - Lack of knowledge of available resources - Institutional capacity - Managing substance abuse - Lack of professionals willing to accept Medicare or MediCal - COVID

	- Provide local work opportunities, e.g. animal care or street cleaning - Outreach Fair - Expand and enhance wellness opportunities, e.g. physical therapy, acupuncture - Provide vouchers for housing in other communities		

Health Housing and
Community Services Department
Mental Health Division

MEMORANDUM

To: Mental Health Commission
From: Steven Grolnic-McClurg, Mental Health Division Manager
Date: September 14th, 2021
Subject: Mental Health Manager Report

Mental Health Services Report

Please find the attached report on Mental Health Services for August, 2021. Included in the services report for this month are some additions. For the first time, caseload information is included for the Homeless Full Service Program, which currently has 11 open clients. There is also detailed demographic information on clients for the Mobile Crisis Team (MCT), Transitional Outreach Team (TOT), and Crisis, Assessment and Triage Team (CAT). Finally, for the High School Health Center (HSHC), there is a separation of youth who dropped into the HSHC and those who were externally referred by a teacher or parent. For youth who drop into the HSHC, there is always as assessment completed. For external referrals, an assessment is not always completed for the referred youth, as sometimes the referral turns into a consultation for the parent or staff member who made the referral. It is hoped that separating these two categories allows for a better understanding of the work done by HSHC staff.

FYC Clinic Open at 1521 University Avenue

The Family, Youth and Children Clinic has successfully moved to 1521 University Avenue and is now open for services. This move completes the full transition of clinic sites for the Mental Health Division. Both the Adult Clinic and FYC are now housed in sites that provide a welcoming environment for the community to receive services.

Information Requested by MHC

The following topics were requested by the MHC Chair.

Homeless Full Service Partnership Information

The Homeless Full Service Partnership (HFSP) is a new long term treatment program, which began to see clients at the beginning of Spring of 2021. The program is budgeted for a Mental Health Clinical Supervisor, two Behavioral Health Clinicians, two Social Services Specialists, one Mental Health Nurse, and a portion of a

Psychiatrist. While most of the positions on the team are now in place, there remain the following vacancies: one Mental Health Nurse and one Social Services Specialist. The HFSP has 11 clients open as of 9/13/21 and when fully enrolled will have 40-50 clients.

The HFSP aims to enroll homeless or at risk of homeless individuals who are 18 or over in Berkeley, who have a qualifying mental health diagnosis and major functional impairments in related to that mental health diagnosis. In order to serve these individuals, the team operates using the Assertive Community Treatment (ACT) model, where services are provided in a team approach. The team utilizes motivational interviewing (MI) heavily as a treatment modality, and is focused on meeting individuals where they are at. For this reason, the vast majority of services are in the field – usually in encampments or community where someone is regularly located.

The HFSP has access to flexible funding to support individuals in moving forward in their lives. These can be used to surmount a wide variety of barriers, from temporary motel stays to startup costs for an apartment. The HFSP team supports individuals in getting ID's and other documents that are crucial for accessing benefits, and supports individuals in obtaining benefits and, where necessary, representative payee services.

In order to access permanent housing, the HFSP utilizes the Alameda County Coordinated Entry System, which prioritizes homeless individuals based on a vulnerability index, and from which permanent housing vouchers are assigned. For temporary housing, the HFSP utilizes local shelters, the YMCA, and Safer Ground hotel placements for people highly vulnerable to COVID. Of the current 11 clients, 6 are unhoused, 4 are in temporary housing or shelter, and one is currently at Villa Fairmont preparing for discharge to a Board and Care. There are a variety or barriers to housing clients of the HFSP. There is a very limited availability of temporary or longer-term housing and shelters. The process of completing a housing interview assessment and being "document ready", particularly for severely mentally ill and chronically unhoused people, is very complicated and difficult to complete. Finally, HFSP clients' symptoms and impairments interfere with obtaining and maintaining stable housing.

Many HFSP client have substance use issues, and the team takes a harm reduction approach these challenges. We refer individuals who are open to treatment to providers in the Alameda County system of care through the Centerpoint Substance Use treatment Access phone line, which then links clients to substance recovery at the appropriate level (e.g., detox, residential or outpatient treatment, and peer support). For individuals who are not yet ready to change the substance use behavior, we focus on reducing the impacts of their use in their lives and enhancing their motivation for change.

For physical health needs, the HFSP works to connect individuals with a primary care physician (PCP), usually through Lifelong Medical. If someone has a primary care clinician, we support them in following up with their PCP's. For individuals who are not yet willing to engage with a PCP, we support them in getting their physical health care needs met through linkage to the Lifelong street medicine team.

The HFSP is focused in providing care in a way that supports the diversity of our clients. The staffing reflects that diversity, and issues of race, ethnicity, and SOGIE are carefully considered as part of the treatment plan and engagement strategy.

Housing Coordinator Position

All ongoing clients with the mental health division have an assigned clinician who supports that individual in meeting their treatment plan goals, which may include housing. In addition to this, the division added in a Social Services Specialist position several years ago to provide additional support around housing concerns. This position reports to the Mental Health Program Supervisor of Adult Services, and has a varied set of duties, including:

- Coordinating client ranks in the "by name list" for Alameda County, which prioritizes homeless individuals for housing through a vulnerability index. For clients that appear to be ranked incorrectly, supporting the assigned clinician in getting the client re-assessed or providing additional information to support a new ranking.
- Supporting clinicians for unhoused clients who are not on the "by name list" in getting assessed.
- Coordinating transitional and shelter housing information for clinicians, and support placement in these options.
- Supporting clustered housing sites, in particular MLK House, where a set of division mental health clients live.
- Supporting clinicians in coordinating housing opportunities for individual with housing vouchers, supporting efforts to apply for these housing opportunities, and supporting move-in for these clients when they obtain housing.
- Providing general resources to clinicians and clients around housing supports and options.

Collaboration with Santa Rita around Continuity of Care

The Mental Health Division is part of the Alameda County Behavioral Health (ACBH) Plan, and follows ACBH protocols and procedures around supporting individuals in transitioning out of Santa Rita Jail into housing options. This can be challenging for a variety of reasons, including:

- Lack of notice of discharge.
- Discharge late at night or weekends.
- Difficulty having contact with clients in Santa Rita – extremely difficult to access clients when in Santa Rita.
- Lack of housing options available to clients.
- Client not being interested in available housing options.

ACBH is currently developing a variety of changes to services at Santa Rita, and as a contract provider, we look forward to these changes.

CalAim and In Lieu of Services

CalAim is a large set of reforms and changes to the Medi-Cal system in California. One of the first parts of CalAim that will be implemented is Enhanced Care Management (ECM). ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need Medi-Cal managed care health plan (MCP) Members through systematic coordination of services and comprehensive, community-based care management. Please note that ECM is to be implemented by the Medi-Cal Managed Care Plan, which in Alameda County is either Alameda Alliance or Anthem Blue Cross.

ECM is part of a broader population health system design within CalAIM, under which MCPs will systematically risk-stratify their enrolled populations and offer a menu of care management interventions at different levels of intensity, with ECM at the highest intensity level. Both Alameda Alliance and Anthem Blue Cross have filed plan to begin implementing ECM, which will include the populations that were served through the Whole Person Care Pilot in Alameda County.

In lieu of services, or ILOS, are medically appropriate and cost-effective alternative services or settings to those covered under the Medi-Cal State Plan. Federal regulation allows states to offer ILOS as an option for Medicaid managed care organizations. DHCS strongly encourages MCPs to offer a robust menu of ILOS to comprehensively address the needs of Members with the most complex health issues, including conditions caused or exacerbated by lack of food, housing, or other social drivers of health. ILOS are optional services for MCPs to offer and are optional for managed care Members to receive. Please note again that the Medicaid managed care plans are the entities that will decide if they are going to provide these services, and will then identify how members will become eligible for these services.

The Mental Health Division is working actively with ACBH to track the implementation of CalAim in Alameda County, and to ensure that our clients are able to access these services when they become available.

MHSA INN Encampment Wellness Program Timeline and Information

The MHSA Innovation Encampment Wellness Project has had informal input from the MHOAC, and we are collecting additional input from stakeholders and COB on the final draft that we will submit for approval. The main thrust of the project, at this time, is to support individuals in encampments in their wellness through the use of both a CBO team that has peer providers and the employment of individuals in the encampments themselves in these efforts.

Community Health Record Implementation

The City Attorney's office recently approved the agreement for the Community Health Record (CHR), and the MH Division now has both legal and IT approval. We are now

working with Alameda County Care Connect towards getting the agreement signed, and then will begin the process of implementing the CHR in the division.

Housing Status of Clients

There is no existing report that provides the housing status of all open clients. This means that there is no way to get a report through Clinician's Gateway or YellowFin that will give the housing status of all clients. In order to be able to report this, we would need to create and maintain a separate "registry" of housing status for MH clients. While there is not a plan yet for the creation or maintenance of such a "registry," the MH Division appreciates the input of the MHC around the importance of this information and is actively working to see how to implement a housing registry.

Berkeley Mental Health Caseload Statistics
for August 2021

Adult Services	Intended Ratio of staff to clients	Clinical Staff Positions Filled	# of clients open this month	Average Monthly System Cost Previous 12 Months	Fiscal Year 2022 (July '21-June '22) Demographics as of Aug 2021
Adult, Older Adult and TAY Full Service Partnership (AFSP) (Highest level outpatient clinical case management and treatment)	1-10 for clinical staff.	4 Clinicians .5 Team Lead	66	$5,910	64 Clients API: 1 Black or African-American: 18 Hispanic or Latino:2 Other/Unknown: 31 White: 12 Male: 39 Female: 25
Adult FSP Psychiatry	1-100	.75 FTE	60		
AFSP FY21 Mental Health Division Estimated Budgeted Personnel Costs, including Psychiatry and Medical Staff (FY22 not yet available)			$2,037,600		
Homeless Full Service Partnership (HFSP) (Highest level outpatient clinical case management and treatment)	1-8 for clinical staff	3 Clinicians, 1 Team Lead	12	$5,984	11 Clients API: 0 Black or African-American: 3 Hispanic or Latino:1 Other/Unknown: 6 White: 1 Male: 6 Female: 5
HFPS Psychiatry	1-100	.2 FTE	10		
HFSP FY22 Mental Health Division Estimated Budgeted Personnel Costs, including Psychiatry and Medical Staff (FY22 not yet available)			TBD		
Comprehensive Community Treatment (CCT) (High level outpatient clinical case management and treatment)	1-20	8 Clinicians 1 Manager	176	$2,384	169 Clients API: 4 Black or African-American: 41 Hispanic or Latino:11 Other/Unknown: 75 White: 38 Male: 87 Female: 82
CCT Psychiatry	1-200	1 FTE	143		

CCT FY21 Mental Health Division Estimated Budgeted Personnel Costs, including Psychiatry and Medical Staff (FY22 not yet available)			$2,617,010		
Focus on Independence Team (FIT) **(Lower level of care, only for individuals previously on FSP or CCT)**	1-20 Team Lead, 1-50 Post Masters Clinical 1-30 Non-Degreed Clinical	1 Clinical Supervisor, I Licensed Clinician, 1 CHW Sp./ Non-Degreed Clinical	97	$983	96 Clients API: 2 Black or African American: 26 Hispanic or Latino: 2 Other/Unknown: 35 White: 31 Male: 57 Female: 39
FIT Psychiatry	1-200	.5	90		
FIT FY21 Mental Health Division Estimated Budgeted Personnel Costs, including Psychiatry and Medical Staff (FY22 not yet available)			$900,451		

Family, Youth and Children's Services	Intended Ratio of staff to clients	Clinical Staff Positions Filled	# of clients open this month	Average Monthly System Cost Last 12 months	Fiscal Year 2022 2022 (July '21-June '22) Demographics as of August 2021
Children's Full Service Partnership (CFSP)	1-8	1.5 Clinical	9	$4,734	8 Clients American Indian: 1 API: 0 Black or African-American:3 Hispanic or Latino: 1 Other/Unknown: 2 White: 1 Male: 6 Female: 2
CFSP Psychiatry	1-100	0	1		
CFSP FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available)			$489,235		
Early and Periodic Screening, Diagnostic and Treatment Prevention (EPSDT) /Educationally Related Mental Health Services (ERMHS)	1-20	2.5 Clinical	46	$2.237	42 Clients American Indian: 1 API: 1 Black or African-American: 14 Hispanic or Latino: 9 Other/Unknown: 6 White: 11 Male: 19 Female: 23
ERMHS/EPSDT Psychiatry	1-100	0	3		
EPSDT/ERMHS FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available)			$1,062,409		
High School Health Center and Berkeley Technological Academy (HSHC)	1-6 Clinician (majority of time spent on crisis counseling)	2.5 Clinical	Drop-in: 31 Externally referred: 33 Ongoing tx: 11 Groups: 0		N/A
HSHC FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available)			$396,106		

Crisis and ACCESS Services	Staff Ratio	Clinical Staff Positions Filled	Total # of Clients/Incidents	MCT Incidents Detail	Calendar Year 2021 (Jan '21-Dec '21) Demographics – From Mobile Crisis Incident Log (through August 2021)
Mobile Crisis (MCT)	N/A	2 Clinician filled at this time	• 115 Incidents • 44 5150 Evals • 7 5150 Evals leading to involuntary transport	• 55 Incidents: Location - Phone • 50 Incidents: Location - Field • 2 Incidents: Location - Home	540 Clients API: 31 Black or African-American: 113 Hispanic or Latino: 22 Other/Unknown: 245 White: 129 Male: 248 Female: 246 Transgender: 7 Unknown: 39
MCT FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available)			$771,623		
Transitional Outreach Team (TOT)	N/A	1 Licensed Clinician, 1 Case Manager (both sometimes reassigned due to staffing needs in other units)	55 Incidents	N/A	248 Clients API: 21 Black or African-American: 52 Hispanic or Latino: 13 Other/Unknown: 97 White: 65 Male: 116 Female: 109 Transgender: 4 Unknown: 9
TOT FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available))			$272,323		
Community Assessment Team (CAT)	N/A	1 Team Lead, 1 Clinician, 1 Non-Degreed Clinical	108 Incidents	N/A	350 Clients API: 11 Black or African-American: 92 Hispanic or Latino: 21 Other/Unknown: 128 White: 98 Male: 163 Female: 168 Transgender: 2

					Unknown: 17
CAT FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available))			$735,075		

Not reflected in above chart is Early Childhood Consultation, Wellness and Recovery Programming, or Family Support.

*Average System Costs come from YellowFin, and per ACBH include all costs to mental health programs, sub-acute residential programs, hospitals, and jail mental health costs.

Works-Wright, Jamie

From: Klatt, Karen
Sent: Friday, September 10, 2021 1:03 PM
To: Berkeley/Albany Mental Health Commission
Subject: Fw: Suicide Prevention Week Challenge #5: Light a Candle for World Suicide Prevention Day
Attachments: 2021 SPW candle_instagram -english.png; 2021 SPW candle_instagram - span1.png

Hi Jamie,

Can you please share this with the Mental Health Commission?

Thanks much!

Karen

Karen Klatt, MEd
MHSA Coordinator
City of Berkeley, Mental Health Division
3282 Adeline Street, Berkeley CA 94703
(510) 981-7644 – Office
(510) 849-7541 – Cell
KKlatt@cityofberkeley.info

Greetings!

It is World Suicide Prevention Day! Each year on September 10th, World Suicide Prevention Day encourages worldwide commitment and action to prevent suicide and to support those who have been impacted by suicide. On this special day, you can join thousands of others in showing your support for suicide prevention and remembering loved ones lost to suicide by lighting a candle near a window or on social media at 8 p.m.

Forwarded are additional resources from the Mental Health Services Act (MHSA) funded Prevention and Early Intervention (PEI) Statewide Projects "Know the Signs" campaign:

- The brochure "Help and Support After Suicide: Information and Resources to Promote Healing" explains complicated grief and offers resources for individuals who have lost a loved one to suicide. The brochure and a California Survivor of Suicide Loss Program Directory can be found on the "Reach Out" page of this website: www.SuicideisPreventable.org

- Friends for Survival has offered support for those bereaved by a suicide death for over 30 years. Call their help line, sign up to receive their newsletter, and visit their web site for links to resources and reading material. Toll Free Suicide Loss Helpline: 1-800-646-7322.

- The American Foundation for Suicide Prevention is a national organization with chapters in all 50 states that is dedicated to saving lives and bringing hope to those affected by suicide. Their web site includes a wide range of resources and educational materials for survivors of suicide loss.

- To learn more about World Suicide Prevention Day, visit https://www.iasp.info/wspd2021/.

Thanks,

Karen

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MHSA Coordinator
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Works-Wright, Jamie

From: Margaret Fine <margaretcarolfine@gmail.com>
Sent: Sunday, September 5, 2021 6:52 PM
To: Works-Wright, Jamie
Subject: Fwd: Crisis Response Models Report by RDA Attached
Attachments: Berkeley-HHCSD_SCU_Crisis-Response-Models-Report_20210903-FINAL.pdf

Dear Jamie,

I hope you're doing well.

I am passing along the attached Crisis Response Models Report developed by Research Development Associates (RDA).

Would you please be so kind and forward this email and the attached report to the Mental Health Commissioners and the public?

The Table of Contents include:

- Introduction

- Crisis Response Models: An Overview

- Components of Crisis Response Models:

Accessing Call Center, Triage & Dispatch, Assessing for Safety, Hours of Operation, Types of Calls, Scope of Services, Training, Equipment, Transport, Follow-Up & Service Linkage

- Program Administration:
Administrative Structure, Financing, Program Evaluation, Coordination

- Program Planning Process:
Planning Timeline & Community Engagement (RDA report coming soon)

- Lessons Learned

- Appendices:

SAMHSA's National Guidelines for Behavioral Health Crisis Care (released in 2020)
Sample Outlines of Types of Scenarios for Crisis Response Teams
Crisis Response Programs Researched by RDA – Summary of Key Components

Below are screenshots of the Appendix C Chart of Models researched by RDA.

City of Berkeley

Crisis Response Models Report

RDA CONSULTING

CITY OF BERKELEY

City of Berkeley
Specialized Care Unit Model Recommendations
Crisis Response Models Report

Caroline de Bie

Sarah Ferrell

Sasha Gayle-Schneider

Jamie Dorsey

Nicole Gamache-Kocol

Kevin Wu

This report was developed by Resource Development Associates under contract with the City of Berkeley Health, Housing & Community Services Department.

Resource Development Associates, September 2021

Table of Contents

Introduction

In response to the killing of George Floyd by Minneapolis police in May 2020 and the ensuing protests across the nation for this and many other similar tragedies, a national conversation emerged about how policing can be done differently in local communities. The Berkeley City Council initiated a broad reaching process to reimagine policing in the City of Berkeley. As part of that process, in July 2020, the Berkeley City Council directed the City Manager to pursue reforms to limit the Berkeley Police Department's scope of work to "primarily violent and criminal matters." These reforms included, in part, the development of a Specialized Care Unit (SCU) pilot to respond to mental health crises without the involvement of law enforcement.

In order to inform the development of an SCU, the City of Berkeley contracted with Resource Development Associates (RDA) to conduct a feasibility study that includes community-informed program design recommendations, a phased implementation plan, and funding considerations. As part of this feasibility study, RDA reviewed the components of nearly 40 crisis response programs in the United States and internationally, including virtually meeting with 10 programs between June and July 2021. This report provides a synthesized summary of RDA's findings, including common themes that emerged from across the programs, how they were implemented, considerations and rationale for design components, and overall key lessons learned. Please see the table below for a list of the programs that RDA reviewed. For the first nine programs listed (in bold and italics), RDA conducted phone interviews with representatives to obtain a further understanding of their program models; these programs are cited more often in this report because RDA had more details about them. For the remaining programs listed, RDA reviewed information that was available online. For a tabular summary of the key components of each crisis response program that RDA reviewed, please see Appendix C at the end of this report.

Additionally, SAMHSA's summary of its National Guidelines for Behavioral Health Crisis Care (released in 2020) is included in Appendix A of this report.

Program Name	Location
B-HEARD (the Behavioral Health Emergency Assistance Response Division)	***New York, NY***
Crisis Assistance Helping Out On The Streets (CAHOOTS)	***Eugene, OR***
Crisis Response Pilot	***Chicago, IL***
Expanded Mobile Crisis Outreach Team (EMCOT)	***Austin, TX***
Mental Health First / Anti-Police Terror Project	***Sacramento and Oakland, CA***
Portland Street Response	***Portland, OR***

Program Name	Location
REACH 24/7 Crisis Diversion	***Edmonton, Alberta, Canada***
Support Team Assisted Response (STAR)	***Denver, CO***
Street Crisis Response Team (SCRT)	***San Francisco, CA***
Albuquerque Community Safety Department	Albuquerque, NM
Boston Police Department's Co-Responder Program	Boston, MA
Community Assessment & Transport Team (CATT)	Alameda County, CA
Community Paramedicine	California (statewide)
Crisis Call Diversion Program (CCD)	Houston, TX
Crisis Now	National model (via SAMHSA)
Crisis Response Unit	Olympia, WA
Cuyahoga County Mobile Crisis Team	Cuyahoga County, Ohio
Department of Community Response	Sacramento, CA
Department of Community Solutions and Public Safety	Ithaca, NY
Downtown Emergency Service Center (DESC) Mobile Crisis Team	King County, WA
Georgia Crisis & Access Line (GCAL)	Georgia (statewide)
Los Angeles County Department of Mental Health – ACCESS Center	Los Angeles County, CA
Los Angeles County Department of Mental Health – Co-Response Program	Los Angeles County, CA
Los Angeles County Department of Mental Health – Psychiatric Mobile Response Teams (PMRT)	Los Angeles County, CA
Mobile Assistance Community Responders of Oakland (MACRO)	Oakland, CA
Mental Health Acute Assessment Team (MHAAT)	Sydney, Australia
Mental Health Mobile Crisis Team (MHMCT)	Nova Scotia, Canada
Mobile Crisis Assistance Team (MCAT)	Indianapolis, IN
Mobile Crisis Rapid Response Team (MCRRT)	Hamilton, Ontario, Canada
Mobile Emergency Response Team for Youth (MERTY)	Santa Cruz, CA
Mobile Evaluation Team (MET)	East Oakland, CA
Psykiatrisk Akut Mobilitet (PAM) Unit, the Psychiatric Emergency Response Team	Stockholm, Sweden

Program Name	Location
Police and Clinician Emergency Response (PACER)	Australia (several locations)
Seattle Crisis Response Team	Seattle, WA
Street Triage	England (several locations)
Therapeutic Transportation Pilot Program/Alternative Crisis Response	Los Angeles City and County, CA
Toronto Crisis Response	Toronto, Ontario, Canada

Crisis Response Models: An Overview

Of the crisis response program models reviewed, almost all specify that they respond to mental health and behavioral health concerns in their communities. Some models additionally specify that they respond to non-emergency calls, crises or disturbances related to substance use, homelessness, physical assault and sexual assault, family crises, and/or youth-specific concerns, as well as conduct welfare checks.

In California, Alameda County has the highest rate of 5150 psychiatric holds in the entire state.[1] Of those Alameda County individuals placed on a 5150 psychiatric hold that were transferred to a psychiatric emergency services unit, 75-85% of the cases did not meet medically necessary criteria to be placed in inpatient acute psychiatric services. This demonstrates an overuse of emergency psychiatric services in Alameda County, which creates challenges in local communities such as having lengthy wait times for ambulance services when these ambulances are tied up transporting and waiting to discharge individuals on 5150 holds at psychiatric emergency service units.

Mental health crises are varied - they affect individuals across their lifespans, manifest in a variety of behaviors, and exist on a spectrum of

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[1] INN Plan – Alameda County: Community Assessment and Transport Team (CATT) – October 25, 2018. (2018, October 25). *California Mental Health Services Oversight and Accountability Commission*. http://www.mhsoac.ca.gov/document/inn-plan-alameda-county-community-assessment-and-transport-team-catt-october-25-2018 & https://mhsoac.ca.gov/sites/default/files/documents/2018-10/Alameda_INN%20Project%20Plan_Community%20Assessment%20and%20Transport%20Team_8.6.2018_Final.pdf

severity and risk. A crisis response system ultimately seeks to provide care to individuals in the midst of a mental health crisis, keeping the individual and their surrounding community safe and healthy, and preventing the escalation of the crisis or exacerbating strains to mental and emotional well-being. As such, there are many considerations for the design of a mental health crisis response system that addresses the current shortcoming or flaws in existing models around the country and internationally.

Traditionally, the U.S. crisis response system has been under the purview of local police departments, typically with the support of local fire departments and emergency medical services (EMS), and activated by the local 911 emergency phone line. Over time, communities have responded to the need for a response system that better meets the mental health needs of community members by activating medical or therapeutic personnel in crisis response instead of traditional first responders (i.e., police, fire, EMS).

Term	Definition
Traditional Crisis Response Model	For the purposes of this report, we assume a traditional crisis response model includes having all crises routed through a 911 center that then dispatches the local law enforcement agency (as well as fire department and/or EMS, if necessary) to respond to the crisis.
Co-Responder Model	Co-responder models vary in practice, but they generally involve law enforcement officers and behavioral health clinicians working together to respond to calls for service involving an individual experiencing a behavioral health crisis.
911 Diversion Programs	Programs with processes whereby police, fire, and EMS dispatchers divert eligible non-emergency, mental health-related calls to behavioral health specialists, who then manage crisis by telephone and offer referrals to needed services.
Alternate Model	Emerging and innovative behavioral health crisis response models that minimize law enforcement involvement and emphasize community-based provider teams and solutions for responding to individuals experiencing behavioral health crises.

Like a physical health crisis that requires treatment from medical professionals, a mental health crisis requires responses from mental health professionals. Tragically, police are 16 times more likely to kill someone

with a mental health illness compared to others without a mental illness.[2] A November 2016 study published in the American Journal of Preventative Medicine estimated that 20% to 50% of fatal encounters with law enforcement involved an individual with a mental illness.[3] As a result, communities have begun to consider the urgent need for crisis response models that include mental health professionals rather than police.

In the current national discussion about appropriate crisis response strategies for individuals experiencing mental health crises, the prominent concerns voiced have typically focused on the safety of crisis responders and community members, the funding of such programs, and balancing a sense of urgency to implement new models quickly with the need for intentional planning and preparation. In order to understand the current models that exist, RDA reviewed nearly 40 national and international crisis response programs and specifically interviewed staff from 9 programs about their:

- Program planning efforts, including community engagement strategies, coordinating across city agencies and partner organizations, and program planning, implementation, and evaluation activities;
- Models' key elements, including dispatch, staffing, transport capabilities, follow-up care, and more;
- Program financing;
- Other considerations that were factored into their program planning; and
- Key lessons learned or advice for the City of Berkeley's implementation of its SCU.

Components of Crisis Response Models

While each crisis response program was designed to meet the needs of its local community, there are several overarching components that were common across the programs that RDA explored. The majority of crisis response programs use their community's existing 911 infrastructure for dispatch. Most programs respond to mental health and behavioral health calls where they engage in de-escalation, assessment, referral, and

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[2] Szabo, L. (2015, December 10). People with mental illness 16 times more likely to be killed by police. *USA Today*. https://www.usatoday.com/story/news/2015/12/10/people-mental-illness-16-times-more-likely-killed-police/77059710/

[3] DeGue, S., Fowler, K.A., & Calkins, C. (2016). Deaths Due to Use of Lethal Force by Law Enforcement. *American Journal of Preventive Medicine, 51* (5), S173-S187. https://www.ajpmonline.org/article/S0749-3797(16)30384-1/fulltext

transport. Nearly all programs recognize the need to operate 24/7. Staffing structure varies by the needs of the community, but many response team units are staffed by teams of two to three individuals and can include a combination of mental health professionals, physical health professionals, and peers with lived experience. Many teams arrive in plainclothes or T-shirts with logos in a vehicle equipped with medical and engagement items. Teams typically receive skills-based training in de-escalation, crisis intervention, situational awareness, and communication. Crisis teams will either transport clients themselves or call a third party to transport, depending on the legal requirements and staffing structure of the crisis response team. Programs varied in their inclusion and provision of follow-up care.

Underneath the high-level similarities of the crisis response models that RDA researched are the tailored nuances that each program adapted to its local needs, capacities, and priorities. Below are additional details, considerations, and examples from existing models to further inform the City of Berkeley's development and implementation of its SCU.

Accessing the Call Center

Of the reviewed crisis response programs, the majority use the existing local 911 infrastructure, including its call receiving and dispatch technology and staff. There are several advantages to this approach. The general public is typically familiar with the number and process for calling 911, which can reduce the barrier for accessing services. Also, because 911 call centers already have a triage protocol for behavioral health calls, there can be a more seamless transfer of these types of calls to the local crisis response program. Additionally, some calls might not be reported as a mental health emergency but can be identified as such by trained 911 dispatch staff.

Generally, the administration of 911 varies across the nation. In some locales, 911 is operated by the police department, while in other locales it is administered centrally across all emergency services. Some programs have mental health staff situated in the 911 call center to: a) directly answer calls; b) support calls answered by 911 staff; and/or c) provide services over the phone as a part of the 911 call center's response. In Chicago, in addition to diverting more calls to the crisis response program, the staff of Chicago's Crisis Response Pilot anticipates that having mental health clinicians embedded in their call center to do triage and telemedicine will help them lay the foundation for a smooth transition to 988.

988 is the three-digit phone call for the National Suicide Prevention Lifeline. By July 16, 2022, phone service providers across the country will direct all calls to 988 to the National Suicide Prevention Lifeline, so that Americans in crisis can connect with suicide prevention and mental health crisis

counselors.[4] In California, AB 988 was passed in the State Assembly on June 2, 2021(and is currently waiting on passage by the State Senate) – AB 988 seeks to allocate $50 million for the implementation of 988 centers that have trained counselors receiving calls, as well as a number of other system-level changes.[5] In RDA's research of crisis response models, some programs are actively planning for the upcoming 988 implementation when exploring the functionalities of their local 911 infrastructure and responsibilities; other programs were not differentiating 988 from 911 in the communities. For the purposes of this report, moving forward, we will not differentiate 911 from 988, and will refer to all emergency calls for service as going to 911.

Other programs use an alternative phone number in addition to or instead of 911. These numbers can be an existing non-emergency number (like 211) or a new phone number that goes directly to the crisis response program. Oftentimes a program will utilize an alternative phone number when they believe that people, particularly those disproportionately impacted by police violence, do not feel safe calling 911 because they fear a law enforcement response. Portland's Street Response team & Denver's STAR team use both a non-emergency number and 911, routed to the same call center. This supports community members that are hesitant to use 911 while also ensuring that calls that do come through 911 are still routed to Portland's Street Response team. Overall, designing a system in Portland with both options was intended to increase community members' access to mental health crisis services. Given that Portland's program began on February 16, 2021, not enough time has elapsed for findings to be generated regarding the success of this model. But a current challenge that Portland shared with RDA is that some calls to their non-emergency number have wait times upwards of an hour because their call center needs to prioritize 911 calls.

In other program models, an alternate phone number may have been used in the community for years and, therefore, is a well-known resource. For example, in Canada's REACH Edmonton program, the 211 line is well-used for non-emergency situations, so it is used as the main connection point for its crisis diversion team.

Triage & Dispatch

Once a call is received, dispatch or call center staff will assess whether services could be delivered over the phone or whether the call requires an in-person response, and whether the response should be led by the crisis response team or another entity. Several programs utilize existing

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[4] Federal Communications Commission. (2021). *Suicide Prevention Hotline*. **https://www.fcc.gov/suicide-prevention-hotline** & **https://www.fcc.gov/sites/default/files/988-fact-sheet.pdf**

[5] Open States. (n.d.). *California Assembly Bill 988*. Retrieved September 2, 2021, from **https://openstates.org/ca/bills/20212022/AB988/**

well-used triage tools and/or made modifications to those triage tools based on a renewed emphasis of having non-police responses for mental health crises. Please see Appendix B for sample outlines of types of scenarios for crisis response teams that were shared with RDA. A dispatch's assessment of mental health related calls is dependent on the services provided by the local mental health crisis response team, an assessment of the situation and the caller's needs, who the caller has identified as the preferred response team, and any other safety concerns.

Some programs prioritize staff assignment based on call volume and need, such as programs that have chosen to pilot non-police crisis response teams in specific geographic locations within their jurisdiction. In these programs, the call center must, therefore, determine the location of the requested response when dispatching a crisis response team. For example, Chicago's Crisis Response Pilot has four teams that are assigned to different areas of the city based on their local ties and expertise of community needs; each team, therefore, only responds to calls that come from their assigned area. When programs are able to scale their services and hire more staff, many pilot programs plan to expand their geographical footprints.

Many crisis response teams are dispatched via radio or a computer-aided dispatch (CAD) system, and some have the ability to listen in on police radio and activate their own response if not dispatched. Of the nine programs that RDA interviewed, the Eugene CAHOOTS program allows its team to be self-dispatched, the Denver STAR program allows its team to directly see what calls are in the queue so they can be more proactive in taking and responding to calls, and the San Francisco SCRT program allows its team to respond to incidences that they witness while being out in the streets. Regarding the ability to self-dispatch, San Francisco's SCRT program is currently figuring out the regulatory requirements that might prohibit self-dispatching paramedics because they must be dispatched through a dispatch center.

Having multiple opportunities to engage the crisis response team is important to ensure community members have the most robust access to the service. For example, in Denver, their police, fire, and EMS can call their Support Team Assisted Response (STAR) team directly. Across all incidents that the Denver STAR team responded to in the first six months of its pilot implementation, it was activated by 911 dispatch in 42% of incidents, by police/fire/EMS in 35% of incidents, and self-activated in 23% of incidents.[6] These data from the Denver STAR team demonstrate how, especially in the early stages of a new program's implementation, new processes and relationships are continually being developed, learned, refined, and implemented. For this reason, it is beneficial to have safeguards in place in triage and dispatch processes so that the crisis

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[6] Denver STAR Program. (2021, January 8). *STAR Program Evaluation*. **https://www.denverperfect10.com/wp-content/uploads/2021/01/STAR_Pilot_6_Month_Evaluation_FINAL-REPORT.pdf**

response team can be flexible in responding to the various ways in which crisis response calls originate.

Assessing for Safety

The presence of weapons or violence are the most common reasons why a crisis response team would not be sent into the field. Some of the reviewed programs only respond to calls in public settings and do not go to private residences as an effort to protect crisis team staff, though this was the case in a few of the 40 reviewed programs. Calls that are deemed unsafe or not appropriate for a crisis response team will often be responded to by police, co-responder teams, police officers trained in Critical Intervention Team (CIT) techniques, or other units within the police department. Many alternative models have demonstrated that the need for a police response is rare for calls that are routed to non-law enforcement involved crisis response teams. For instance, in 2019, Eugene's Crisis Assistance Helping Out On The Streets (CAHOOTS) team only requested police backup 150 times out of 24,000 calls, or in fewer than one percent of all calls received by the crisis team;[7] this demonstrates that effective triage assessments and protocols do work in crisis response models.

Several of the programs interviewed by RDA mentioned that they are currently evaluating options for their non-police crisis response teams to respond to situations that may involve weapons or violence. These are situations that would otherwise be scenarios that default to a police response. These programs are aware of the risks of police responses to potentially escalate situations that could otherwise be deescalated with non-police involved responses and are trying to find ways to reduce those types of risks.

The types of harm and concerns for safety that should be assessed are not only for crisis response team staff, but also for the individual(s) in crisis and surrounding bystanders or community members. SAMHSA's best practices on behavioral health crisis response underscores that effective crisis care is rooted in ensuring safety for all staff and consumers, including timely crisis intervention, risk management, and overall minimizing need for physical intervention and re-traumatization of the person in crisis.[8] When call center staff deem a call safe and appropriate for the crisis response team, they will assign the call to the crisis response team. There may be multiple calls and situations happening concurrently, in which case the call center staff

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[7] White Bird Clinic. (n.d.). *What is CAHOOTS?*. Retrieved August 29, 2021, from **https://whitebirdclinic.org/what-is-cahoots/**

[8] Substance Abuse and Mental Health Services Administration (SAMHSA). (2020). *Crisis Services – Meeting Needs, Saving Lives*. **https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-08-01-001%20PDF.pdf** (page 32)

prioritize the calls based on pre-established criteria, such as acuity and risk of harm.

Crisis Response Teams Increase Community Safety

New York City's Behavioral Health Emergency Assistance Response Division (B-HEARD) program is being piloted in a region that receives the city's highest number of mental health emergency calls.[9] In the first month of implementation, the program demonstrated:

- Increased rates of people accepting care from the B-HEARD team compared to traditional 911 response teams.
- The proportion of people transported by the crisis response team to the hospital for more care was far smaller than the proportion transported with their traditional 911 response.
- An anticipated increase of 911 operators routing mental health emergency calls to the B-HEARD team.

"A smarter approach to public health and public safety. A smarter use of resources. And the evidence — from Denver to New York — shows that responding with care works."

- U.S. Representative Jamaal Bowman, D-NY

Hours of Operation

Because a mental health crisis can happen at any time, many programs have adopted a 24-hour model that supports the community seven days a week; of the 40 programs that RDA reviewed, 12 have adopted a 24/7 model. Some programs that are in their early phases of implementation have launched with initially limited hours but have plans to expand to 24/7 coverage once they are able to hire more staff for crisis response teams. If a program uses 911 as a point of access for the crisis response team, then there may be a community perception or expectation that the crisis response team also operates 24/7 the same way that 911 operates 24/7.

Other programs with more restricted resources often have limited hours; some offer services during business hours (9am to 5pm, Monday through Friday) while others offer services after-hours. Using historical data to prioritize coverage during times with highest call volumes can help a program adapt to local needs. For example, Mental Health First Oakland currently responds to calls Friday through Sunday from 7pm to 7am

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[9] Shivaram, D. (2021, July 23). Mental Health Response Teams Yield Better Outcomes Than Police In NYC, Data Shows. *National Public Radio (NPR)*. https://www.npr.org/2021/07/23/1019704823/police-mental-health-crisis-calls-new-york-city#:~:text=Hourly%20News-,New%20York%20City%20Mental%20Health%20Response%20%20Teams%20Show%20Better%20Results,were%20admitted%20to%20the%20hospital.

because they have found that those times are when mental health services are unavailable but need is high.

Types of Calls

Some crisis response programs only respond to specific call types, such as calls pertaining to mental health, behavioral health, domestic violence, substance use, or homelessness. A fraction of programs only respond to acute mental health situations, such as suicidal behavior, or conversely only non-acute mental health calls, such as welfare checks. And, some crisis response programs respond to any non-emergency, non-violent calls, which may or may not include mental health calls. Every program is unique in the calls that they are currently responding to as well as how agencies coordinate for different types of calls. Additionally, given that many programs are actively learning and adapting their models, what and how they respond to calls is evolving.

The most common types of calls that programs are responding to are calls regarding trespassing, welfare checks, suicidal ideation, mental health distress, and social disorder. Several programs mentioned that their main call type - trespassing - is to move an unwanted person, usually someone that is unsheltered and sitting outside the caller's home or business. While programs provide this service, many advocate for increased public education around interacting with unhoused residents and neighbors without the need to call for a third-party response.

The programs in New York City, Chicago, and Portland shared with RDA that they are keeping their scopes of services small for their current pilot implementations. At a later time, they will learn from the types of calls receive and determinations made in order to determine how they will expand their program to respond to more situations (e.g., including serving more types of crises, more types of spaces like private residences, etc.).

In order to demonstrate the variety of incidents that different programs respond to, below are highlights regarding the types of calls that some of the programs that RDA interviewed respond to:

- New York City's B-HEARD program is currently responding to calls regarding suicidal ideation with no weapons, mental health crisis, and calls signaling a combination of physical health and mental health issues. For calls where weapons are involved or are related to a crime, NYPD is the initial responder. The B-HEARD program provides transport and linkage to shelters, where the shelters then provide follow-up services.
- Chicago's Crisis Response Pilot is determining how they will address "low-level crimes" and crimes related to homelessness, especially if the root cause of the crime is an unmet behavioral health and/or housing need. The program does not have an official protocol or decision tree yet for determining which calls it will respond to. But,

its emphasis is on responding to mental health crisis and mental health needs.

- The Portland Street Response program is currently only responding to calls regarding crises that are happening outdoors or public settings (e.g., storefronts), not in private residences. The majority of their calls are related to substance use issues, co-occurring mental health and substance use issues, and welfare checks. The program cannot respond to suicide calls because of a Department of Justice (DOJ) contract that the City of Portland has that would require the Portland Street Response Program to appear before a judge and renegotiate that contract that the city currently has; this process would take at least two years to happen.
- Denver's STAR program currently responds primarily to calls where individuals have schizophrenia, bipolar disorder, major depression, and/or express suicidal thoughts but have no immediate plans to act upon them. The STAR program also conducts many Welfare checks. The program is currently primarily dealing with issues related to homelessness because its pilot rolled out in Denver's downtown corridor where there is a high number of unsheltered individuals.

Services Provided Before, During, and After a Crisis

The reviewed programs offer a variety of services before, during, and after a mental health crisis. Regarding services provided before crises occur, some programs view their role as supporting individuals prior to crisis, including proactive outreach and building relationships in the community with individuals. Portland's Street Response team contracts with street ambassadors with lived experience (via a separate contract with a local CBO) that do direct outreach to communities; street ambassadors work to explain the team's services and ultimately increase trust. Portland's Street Response team also works with nursing students who provide outreach and medical services to nearby encampments. Mental Health First has a strong cohort of repeat callers who request accompaniment through issues they are facing that the team will go into the field to provide – these services can help them avoid escalating into a crisis. Denver's STAR program initiates outreach with local homeless populations to ensure they have medicines and supplies. These proactive efforts are examples of crisis response teams supporting potential individuals before they are in crisis, and thus also promoting their overall health and well-being.

During a crisis response, most programs offer various crisis stabilization services, including de-escalation, welfare checks, conflict resolution and mediation, counseling, short-term case management, safety planning, assessment, transport (to hospitals, sobering sites, solution centers, etc.), and 5150 evaluations. To engage the individual in crisis, staff will provide supplies to help meet basic needs with items such as snacks, water, and clothing. If there is a medical professional on the team, they can provide

medical services including medical assessments, first aid, wound care, substance use treatment (i.e., medicated-assisted treatment), medication assistance and administration, and medical clearance for transport to a crisis stabilization unit (CSU).

After a crisis, the teams may provide linkage to follow-up care. Some crisis response teams do short-term case management themselves, but most refer (and sometimes transport) individuals to other providers for long-term care. Referrals can be a commonly provided service of a crisis response program. For example, 41% of Denver STAR's services are for information and referrals.[10] Many programs have relationships with local community-based organizations for providing referrals and linkages, while some programs have a specific protocol for referring individuals to a peer navigation program or centralized care coordination services.

[10] Alvarez, Alayna. (2021, July 21). Denver's pilot from police is gaining popularity nationwide. *Axios*. **https://www.yahoo.com/now/denver-pivot-police-gaining-popularity-122044701.html**

Term	Definition
Transport	Placing an individual in a vehicle and driving them to or from a designated mental health service or any other place.
5150	5150 is the number of the section of the Welfare and Institutions Code which allows an adult who is experiencing a mental health crisis to be involuntarily detained for a 72-hour psychiatric hospitalization when evaluated to be a danger to others, or to himself or herself, or gravely disabled.
Peer Worker	A mental health peer worker utilizes learning from their own recovery experiences to support other people to navigate their recovery journeys.
Medication-Assisted Treatment (MAT)	MAT is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of SUDs.
Narcan	Narcan (Naloxone) is a nasal spray used for the treatment of known or suspected opioid overdose emergencies.
Crisis Stabilization Unit	A mental health voluntary facility that provides a short-term stay for individuals needing additional stabilization services following a behavioral health crisis.
Sobering Center	A facility that provides a safe, supportive environment for publicly intoxicated individuals to become sober.

Staffing Crisis Teams

Most teams include a combination of a medical professional (e.g., an EMT or nurse), a mental health clinician (e.g., a psychologist or social worker), and a peer. Having a variety of staff on a team allows the program to respond to a diverse array of calls, meet most needs that a client might have, and gives the client the ability to engage with whomever they feel most comfortable.

The reviewed programs staffed their crisis teams with a variety of medical professionals. There was consensus among interviewed programs that crisis response team EMTs, paramedics, nurse practitioners, or psychiatric nurse practitioner clinicians should have at least three to five years of experience in similar settings, as well as having comprehensive de-escalation and trauma-informed care training and skills. Austin's Extended Mobile Crisis Outreach Team (EMCOT) program cited that a paramedic's ability to address a client's more acute physical health and substance use

needs is a beneficial diversion away from an EMS or police response.[11] However, in many cities, the skills and expertise of paramedics are not heavily utilized, as many mental and behavioral health calls do not require a high level of medical care. However, a medical professional can be an important addition to the team, especially for services like providing first aid, wound care, the administration of single-dose medication, medication-assisted treatment (MAT) for substance use issues, and 5150 transports. Considerations for which medical professionals should be staffed on a crisis team depends on the types of services the model intends to provide, the historical data on the types of calls or service needs, the local rules for which services can be provided by specific professions, and the overall program budget.

All programs had a mental health provider on their crisis response teams. There is variability in the level of formal education, training, and licensure of the type of mental health provider in each program. Some programs have licensed, masters-level therapists and clinicians (e.g., ASW, LCSW), while other programs utilize unlicensed mental health providers. Considering if a program wants or needs to be able to bill Medicaid or other insurance payors, the ability to place a 5150 hold, as well as the direct costs of providers with differing levels of education and training are examples of considerations and decision points that programs have when determining what type of professional they want to provide mental health services.

Across the programs reviewed and interviewed by RDA, there is variability in the current presence of peer support specialists on teams. By definition, peer workers are "those who have been successful in the recovery process who help others experiencing similar situations."[12] Studies demonstrate that by helping others engage with the recovery process through understanding, respect and mutual empowerment, peers increase the likelihood of a successful recovery. While they do not replace the role of therapists and clinicians, evidence from the literature and testimonials given to RDA leave no doubt about their value added on a crisis response team. Peer support specialists are able to connect with clients in crisis in ways that are potentially very different from how mental health clinicians and medical providers are trained to provide their specific types of services.

Although 21 of the 40 reviewed programs were classified as alternative models for mental health crisis response, it is important to note that co-responder programs, which were 11 of the 40 reviewed programs, include a police officer on the response team. A co-responder program will often

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[11] *Expanded Mobile Crisis Outreach Team*. (n.d.). Integral Care Crisis Services. Retrieved August 29, 2021, from **https://www.austintexas.gov/edims/document.cfm?id=302634**

[12] *Who Are Peer Workers?*. (2020, April 16). Substance Abuse and Mental Health Services Administration (SAMHSA) Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). **https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers**

be used for higher acuity calls that involve the risk of violence by the person in crisis or the risk that the person in crisis has a weapon. As co-responders, police may arrive on site before the rest of the crisis team does. Other models treat the police officer as a back-up personnel, allowing the crisis team to evaluate the level of risk or danger of the situation and then, if de-escalation tactics are unsuccessful, call the police for support.

Team structures vary depending on funding, local salary structures for different types of providers, program design, and program administration. For example, 24-hour programs require more teams and staffing while programs with limited hours will likely have fewer shift rotations and therefore fewer teams. San Francisco's Street Crisis Response Team has six teams with three members per team; shifts are 12 hours long with two teams assigned to each shift. Overlap between the shifts has improved coordination between the teams. Programs with unionized staff (e.g., EMTs, paramedics) require regimented 8-, 10-, or 12-hour shifts, which also influences a team's capacity and scheduling.

Training

Training requirements vary based on the staffing structure and services provided by a crisis response program as well as the specific needs of the local community. Across the board, programs train their staff in crisis intervention topics such as de-escalation, mental health intervention, substance use management, and situational awareness. Many teams are trained together as a cohort to build relationships and trust between staff. Most teams are trained for around 40 hours in the classroom and then supervised in the field. In co-responder teams, police officers often receive 40 hours of Crisis Intervention Team (CIT) Training.

Specialized staff also receive specific training relevant to their role. Dispatch staff typically receive separate training focused on risk assessment and triage. In programs with clinicians embedded within the call center, the clinicians often provide training to other dispatch staff on mental health topics. Interviewed programs also recommended the crisis response team's dispatch team learn to assess call risk level by building an intake/eligibility tool, as well as through risk assessment and motivational interviewing. For both Denver's STAR and Portland's Street Response programs, dispatch staff were trained by and then shadowed Eugene's CAHOOTS dispatch team, leveraging the decades of experience of CAHOOTS' established alternative crisis response model.

Specific de-escalation and crisis intervention training in which programs participate include key strategies to mitigate risk in the field, learning effective radio communication, and motivational interviewing skills. Some interviewed programs shared that substance use training should be attended by all crisis response staff, not just clinicians; for example, Narcan administration, tourniquet application, and harm reduction training are critical training skills for all team members when supporting a client during a substance use emergency.

Training on implicit bias was also regarded as essential among interviewed programs. Many interviewed programs agreed that receiving training in team-building and communication strategies, trauma-informed care, cultural competency, and racial equity advances the intention and principles of their alternate response program.

Equipment: Uniforms, Vehicles, and Supplies

Most teams arrive either in plain clothes or a T-shirt with a logo. Interviewed programs attested that casual clothing helps crisis response teams appear approachable and creates a sense of comfort for the person in crisis. In contrast, programs worried that formalizing their uniforms could trigger negative past experiences that community members have had with institutions (e.g., police, psychiatric hospitals, prisons) and, therefore, escalate someone in crisis. However, EMTs or police in a co-responder team do wear their usual uniform so that they are easily identifiable as first responders.

The types of vehicles and equipment needed for each model vary based on the scope of services provided, types of calls to which the team responds, and the team's staffing structure. The majority of programs have a van or fleet of vans with the program logo on it and are stocked with necessary supplies. Some programs use their vehicles for on-site service delivery, while others use them only for transporting a client to an alternate location. Programs situated within fire departments often have EMTs or paramedics on-staff, so those teams ride in ambulances or vans with transport capabilities. Co-responder programs often use police vehicles, either marked or unmarked.

There are several considerations for how the design of the vehicle increases accessibility and safety for clients, as well as supports the security of providers. Vans should be accessible to wheelchairs so that crisis response teams can provide services within the interior of the van (to ensure client privacy) and in the event of a needed transport. Also, vans equipped with lights allow them to park on sidewalks and increase traffic safety. Several interviewed programs mentioned using Eugene's CAHOOTS program's van specifications. One component of this design is a plexiglass barrier between the van's front and back seats, which protects both the driver and anyone riding in the back in the case of an accident; additionally, the barrier keeps clients in the back of the vehicle and protects the driver from any disruption that could decrease safety during the transport. However, some cities are moving away from including the plexiglass barrier between the front and back seats in their vans due to the stigma and lack of trust it communicates to the client.

Many vehicles and teams are equipped with various technologies, including radios with connection to dispatch, cell phones, and data-enabled tablets for mobile data entry. Denver's STAR program has access to the local 911 dispatch queue to understand what calls are being

assessed and which could potentially use the program's response. The STAR program teams also have direct access to an electronic health record (EHR) system where they can look-up an individual's health history or communicate directly with a client's psychiatrist or case manager and thus provide tailored, high quality of care in real-time.

If crisis response teams provide medical services, they often carry items such as personal protective equipment, wound care supplies, a stethoscope, blood pressure armband, oxygen, and intravenous bags. Teams also often carry engagement items to initiate client interactions and meet basic needs, such as food, water, clothing, socks, cigarettes, "mercy beers," tampons, condoms, and hygiene packs. When it is able to go into the field again, the Mental Health First model intends to use an RV instead of a van, so they can invite clients into the RV for more privacy and then supply them with a variety of supplies for their basic needs (e.g., clothing).

Overall, when deciding the types of uniforms, vehicles, and equipment to obtain, programs considered what would be recognizable, establish expertise, support the service delivery, build trust with those whom they serve, and not trigger or further harm individuals in crisis.

Transport

The ways that programs transport clients to a subsequent location varies in many ways, including when the transport is allowed, who is doing the transport, where clients are transported, and who is affected by the transport decision.

While some programs have the capability to transport clients themselves, others call a third party to do the transport. This depends on whether staff are licensed to do involuntary transports, whether the vehicle is able to transport clients, and whether it is deemed safe to provide transport at that time. Oftentimes, programs will only conduct voluntary transports, and they may pre-establish specific locations or allow the client's location of choice. If clients do not want to be transported to another location, some programs will end the interaction. Because Denver's STAR team does not use an ambulance, they can refuse someone's requested transport to a hospital if a lower level of care is appropriate, such as a sobering center. Some programs conduct involuntary holds, either done by program staff or by calling for police backup. Waiting for police can undermine the level of care provided, a delay which poses a threat to the client's safety and well-being. Portland's Street Response program experiences delays of up to an hour when requesting police for involuntary holds; for this reason, the team hopes to have the ability to do 5150 transports themselves, and in a trauma-informed way that gives individuals a sense of control over the situation. Whether a crisis response team can transport clients, initiate involuntary holds, and/or call police for back-up in these situations are all considerations which implicate the continued involvement of law enforcement in crisis response.

In the transport process, clients may be transported to short- or long-term service providers as well as the client's location of choice. Some short-term programs include a crisis stabilization facility, detox center, sobering center, homeless shelter, primary care provider, psychiatric facilities, diversion and connection center, hospital, and urgent care. Long-term programs include residential rehabilitation and direct admission to inpatient units of psychiatric emergency departments. Building relationships at these destinations and with providers is key to successful warm handoffs and ensuring clients in crisis receive the appropriate care. For example, challenges can arise when bringing someone to an emergency room if the hospital is not fully aware of what the crisis response program is, which makes it more difficult to advocate for the client to receive services.

There are many things to consider about client and provider safety when transporting a client. Some programs do not give rides home and only transport the person to a public place. Others have restrictions on when they will transport a client to a private residence. For example, Denver's STAR team will not take a person home if they are intoxicated and if someone else is in the home because they do not want to put the other person in potential harm. Instead, when responding to an intoxicated individual, the STAR team transports them to a sobering center, detox facility, or similar location of choice. In Portland, first responders and crisis response providers use a risk assessment tool that helps them determine if ambulance transport needs to be arranged. Portland's risk assessment tool asks providers to determine if the individual has received sedation medication in the last six hours, had a Code Gray in the last 6 hours, had a history of violence and/or aggression, had a history of AWOL, or are showing resistance to hospitalization; if the answer is yes to any of these five questions, then they will arrange for ambulance transport for the individual in crisis.

Follow-up Care & Service Linkage

Follow-up care and linkage to services are handled in a variety of ways. Some programs include referrals to internal, non-crisis response program staff as a service provided directly by the crisis response team. When community health workers and peer support specialists are staffed on crisis response teams, they often lead the referral and navigation support role. After responding to a crisis, Portland's Street Response team (an LCSW and paramedic) call a community health worker if the client wants linkages or additional follow-up supports. While referrals and linkages are important to client outcomes and prevention, this kind of follow-up care can be challenging for many programs to do because it can be difficult to find individuals in the community, particularly if they are not stably housed or do not have a working phone. Portland's Street Response team often goes to encampments to provide follow-up care, which is a program element that is also effective as proactive outreach into local communities.

Other programs refer individuals to other external teams or organizations not affiliated with the crisis response team whose primary role is to provide follow-up care to individuals who served by the crisis response team. Olympia's Crisis Response Unit specifically identifies repeat clients for a referral to a peer navigation program for linkage to care. Additionally, many programs have relationships with community-based organizations and refer clients there for follow-up services. Newer programs that have yet to fully launch stated this was a focus of their program design, as well. For example, San Francisco's Street Crisis Response Team partners with a centralized Office of Care Coordination within the San Francisco Department of Public Health that provides clients with linkages to other services; the Street Crisis Response Team essentially embeds this handoff in their own processes.

And, there are some programs that do not include follow-up care within the scope of their services. For example, Eugene's CAHOOTS program has a narrower focus on crisis stabilization and short-term care; they do not provide referrals or linkage to longer-term services for their clients.

Program Administration

Across the crisis response models that RDA researched and interviewed, there was variability in how they are each administered. As each program is constructed around their local agency structures, resources, needs, and challenges, how their programs are administered are also just as adaptive.

Administrative Structure

The administrative structure and placement of crisis response programs varies significantly. Some programs are administered and delivered by the city/county government, some programs are run in collaboration between a city/county government and community-based organizations (CBO), while others are entirely operated by CBOs.

The administration and structure of a crisis response program may be affected by the geographic and/or population size of the local region and what stage of implementation the program is in. For instance, consistent and guaranteed funding helps sustain programs for the long-term, so developing a program within the local municipal structure may be an advantage over contracting the crisis response program to a CBO. Some programs found that staff retention was higher for government positions, due to their generally higher wages and increased benefits compared to what CBOs generally offer**.** Additionally, the use of the existing 911 and dispatch infrastructure may be streamlined for crisis response programs administered by city/county governments because they can be situated within existing emergency response agencies and use existing interagency data sharing and communication processes

more easily. Finally, programs that are situated within a local health system -- such as Departments of Public Health, Behavioral Health, or public hospitals -- may have existing protocols and processes with which to collaborate with CBOs for referral assistance, case management, resourcing, and follow-up service provision.

On the other hand, programs that are primarily administered and staffed through CBOs reported a sense of flexibility and spontaneity in their program design, expansion, and evolution, especially for early-stage pilots that intend to change and grow over time. These programs shared that they experienced reduced bureaucratic barriers that were conducive to community engagement and program redesign. Additionally, most programs that included peer support specialists in their crisis response program had these roles sourced by CBOs – these peer support specialists were either fully integrated into crisis response teams or were referred to by crisis response teams to provide linkage and follow-up services.

Though there is variety in what entity administers crisis response programs, who sources or contracts the crisis responders, and where funds are generated, all programs require cross-system coordination for designing the program and implementing the dispatch, training, funding, and program evaluation/monitoring activities.

Staffing and sourcing a crisis response program entirely by volunteers can also be helpful in reducing barriers for potential providers to enter this professional field, elevating lived experience of staff, addressing community distrust of the police-involved response system, and building a mental health workforce. However, currently, all-volunteer models face challenges in having consistent and full staffing coverage, which limits a program's overall service provision and hours of operation.

Financing

Aside from the health benefits of increasing mental health and medical resources in crisis responses, there are financial benefits, too. For example, in Eugene, the CAHOOTS program's annual budget is $2.1 million. In contrast, the City of Eugene estimates it would cost the Eugene Police Department $8.5 million to serve the volume and type of calls that are directed to CAHOOTS.[13]

Several cities are funding crisis response systems through the city's general fund, which offers a potentially sustainable funding source for the long-term because it demonstrates that city officials are committed to investing in these services with public funds. To generate these funds, Denver added a sales and use tax in 2019 (one-quarter of a percent) to cover mental health services, a portion of which funds the STAR program.

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[13] White Bird Clinic. (n.d.). *What is CAHOOTS?*. Retrieved August 29, 2021, from **https://whitebirdclinic.org/what-is-cahoots/**

Some cities have funded crisis response programs by reallocating other city funds. Chicago's Police Department currently pays the salary of the CIT-officer in Chicago's crisis response pilot program. Chicago's crisis response pilot also receives additional funding from Chicago's Department of Public Health. Austin's EMCOT program is funded by $11 million reallocated from the Police Department. And Eugene's CAHOOTS program is fully funded through a contract by the Eugene Police Department.

Federal or state dollars have also been used for some crisis response programs. Alameda County's Community Assessment and Transport Team (CATT) is funding by California's Mental Health Services Act (MHSA) Innovation funds. Chicago's current crisis response pilot uses Centers for Disease Control and Prevention (CDC) funding. New York City and Los Angeles both plan to bill Medicaid as a funding source for their emerging crisis response programs. The national Crisis Now program bills per service and per diem for mobile crisis and crisis stabilization services, which is reimbursed by Medicaid.

Some programs are able to leverage private funds to support their services. In addition to the allocation of city funds, Chicago receives funding from foundations and corporations to fund its crisis response program. The Mental Health First program is entirely supported by donations, grants, and volunteer time.

These financing mechanisms provide varying levels of sustainability and predictability, which may affect the longevity of a program and, therefore, its overall impacts. Ensuring that programs can be continuously funded ensures resources go into direct service provision and program administration, rather than on development, fundraising, or grant management. Staff recruitment and retention is also more successful when there is long-term reliability of positions.

Program Evaluation

Many crisis response programs use data to monitor their ongoing progress and successes, modify and expand program pilots, and measure outcomes and impact. Standardizing data collection practices (i.e., data collection tools, measures, values for measures, aligned electronic sources for data entry, etc.) across participating teams and agencies within and across cities/locales, especially for regional plans, supports effective program evaluation and reporting. Addressing this consideration is best done early in program planning because it affects the protocols developed for triage and dispatch, the equipment that crisis response teams use to record service delivery notes or accessing clients' EHR records, the way referrals and hand-offs are conducted, whether or how Medicaid billing/financing will be leveraged, and more. Several cities noted that they incorporated data sharing and access into MOUs that outlined the scope of work. The providers in most programs have access to an electronic health record (EHR) system that they are able to enter

their contact notes into – having access to a centralized data collection portal like this can greatly aid a program's evaluation efforts.

Pilot Program Evaluation Highlight: Denver's Support Team Assisted Response (STAR) Program

Denver planned to evaluate the STAR program after an initial six-month pilot phase. For the evaluation, data was collected from both the 911 CAD database and the Mental Health Center of Denver. Data was kept in separate systems to protect health-related information from the law enforcement database. The program evaluation provided data on incident locations, response time, response dispatch source (i.e., 911, police unit, or STAR-initiated), social demographics of consumers served, services provided, location of client transport/drop-off, and more. The use of two data systems also allowed the program to evaluate what the STAR team identified as the primary issue of concern compared to clinical diagnoses from the health data.[14]

As a result of analyzing these data, Denver identified its program successes and impacts and is committed to expanding the funding and scope of the program. This expansion includes purchasing more vans, staffing more teams, expanding the hours of operation, expanding the service area across the City, hiring a supervisor, and investing in program leadership. Additional plans for future evaluation include building a better understanding of populations served and more rigorous data capture, a longitudinal study to understand consumer long-term outcomes, and a cost-benefit analysis to understand the economic impacts of the program.

Once data is collected, a process for analyzing, visualizing, and reviewing data supports the overall effectiveness of program monitoring, thus contributing to changes to a pilot and the overall outcomes achieved by the program. Some programs have developed internal data dashboards to compile and organize their data in real-time, thus allowing them to review their program data on a weekly basis. And, some programs are also planning for an external evaluation to assist them in developing a broader understanding of their program's impacts for their clients and in the larger community.

[14] Denver STAR Program. (2021, January 8). *STAR Program Evaluation*. https://www.denverperfect10.com/wp-content/uploads/2021/01/STAR_Pilot_6_Month_Evaluation_FINAL-REPORT.pdf

Examples of Metrics that Cities Collect, Review, and Publish Data On

- *Call volume*
- *Time of calls received*
- *Service areas*
- *Response times*
- *Speed of deployment*
- *Determinations and dispositions of dispatch (including specific coding for violence/weapons/emergency)*
- *Which teams are deployed across all emergency response*
- *Actual level of service needed compared to the initial determination at the point of dispatch*
- *Number of involuntary holds that are placed*
- *Number of transports that are conducted*
- *Type of referrals made*
- *Priority needs of clients served (housing, mental health)*
- *Frequency of police involvement*

Making data about crisis response programs publicly available is also important for community transparency and public research. For example, New York City is planning to publish B-HEARD program data on a monthly basis. And, Portland has a public data dashboard for its crisis response program that is updated at least once per week.[15] Such data transparency allows local constituents and stakeholders to check on the progress of their local crisis response program and whether it is making a difference. Such transparency can also contribute to public research and dissemination efforts about emerging alternate crisis response models.

Coordinating the Crisis Response System

Given the complexity of a crisis response system -- from its administrative structure and financing, the technical integration of dispatch with responders, the coordination of referrals and linkages, to client case management -- coordination is an essential, ongoing element of any program. This coordination requires investing in staff time and skills to participate in coordination efforts, focusing on de-siloing all components of crisis response, and effective leadership and vision. Coordination affects financing decisions and contributes directly to client outcomes; therefore, coordination implicates every aspect of program planning, implementation, and evaluation. Overall, program administration benefits

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[15] *Portland Street Response Data Dashboard*. (n.d.). City of Portland, Oregon. Retrieved August 29, 2021, from **https://www.portland.gov/streetresponse/data-dashboard**

from having coordination done at a high level, ensuring there is a person(s) responsible for holding the program at a birds-eye view.

Coordinating services between the crisis response team and community partners includes ensuring there are open communication channels between various entities at a structural level down to a client case management level. At a structural level, it requires investing in staff time, technology, and protocol development, not just at the initial program launch but on an ongoing basis. Based on the program evaluation and data collection design, system-level coordination can support ongoing data review and inform future decisions made about a program.

For example, the managers of San Francisco's Street Crisis Response Team participate in interagency meetings to ensure strategic coordination of service delivery across San Francisco's Department of Public Health, Fire Department, and Office of Care Coordination. Additionally, when Austin's EMCOT program's call center staff integrated the call center technology and co-located their crisis response services within the city's 911 dispatch, the crisis response program had reduced dropped calls, increased communication around safety and risk assessment during triage, more effective handoffs to mental health clinicians for telehealth, and increased deployment of the crisis response team by dispatch.

System-level coordination also has important downstream effects, such as ensuring that first responders (i.e., police, fire, EMS) can call the crisis response team to respond to a situation if they are dispatched first. At a client level, system coordination can support case management, referrals and linkages, and improved client outcomes. For example, Canada's REACH Edmonton program provides governance support and coordination to a network of CBO providers, including facilitating a bimonthly meeting for frontline workers to discuss shared clients. The program shared that for its most complex cases, this coordination significantly increased positive client outcomes. The program also found that they were able to better leverage the expertise of peer support specialists by having a specified coordinator leading these meetings and ensuring their voice and participation was valued. Service providers within this network all utilize the same EHR for documenting and sharing client notes, though the program has encountered challenges in data sharing. Overall, the REACH Edmonton program shared that system-level coordination must be tightly managed but that most program staff and frontline workers do not have the capacity to do so, so having a centralized governance and coordinating body is essential.

Program Planning Process

Planning the large and small details of a crisis response program is an essential part of a successful launch. Although each city will have a different planning process and timeline based on the local community's needs and administrative designs, some common themes emerged across the crisis response models that RDA reviewed.

Planning across city departments typically includes active involvement from emergency medical services, fire, and police as well as leaders from local public health and mental/behavioral health agencies and CBOs. Many cities stated that having emergency responders involved in the collaborative brainstorming and discussions from the earliest planning stages was essential in garnering buy-in from other city or county departments, including identifying the best resource(s) when responding to mental health needs and crises. Planning also requires engaging other entities; for instance, Portland has to negotiate with the local police union for all services provided by Portland's Street Response program. Some cities shared that they are aware of beliefs of local police departments and unions about potentially losing funding for police services when new crisis response services are added to the local infrastructure. But, cities found that when they focused the conversation about shared objectives between the crisis response program and the police, police began to see the program as a resource to them as mental health professionals could often better handle mental health crises because of their training and backgrounds. This alignment on shared goals and values underpins the reason that the Eugene Police Department funds the city's non-police crisis response program, CAHOOTS. Developing a collective and shared narrative around community health and well-being while reducing harm, trauma, and unnecessary use of force, is essential in promoting any crisis response program.

Program planning allows cities to identify elements to include in the pilot that will be investigated throughout the pilot stages. For instance, the planning process may include heat mapping the highest call-volume areas of the city or discussing preliminary milestones to support scaling or expansion of a pilot program. As an example, New York City's B-HEARD model is currently focused on deploying the B-HEARD team using the existing 911 determination process for identifying mental health emergencies; but, in the future, the program will also assess how those determinations are made to improve the determination and dispatch processes. Their sequencing of planning priorities allowed the program to be launched on a shorter timeline while preparing for an iterative evaluation and design process.

In the future, many learnings can be extrapolated from the ways that crisis response programs are being implemented across the United States and internationally. At this point in time, given that many implementations began within the past two years and are still actively evolving and changing, it is premature to pinpoint common themes in how similar and different jurisdictions and communities (e.g., population size, population density, geography, etc.) are unfolding their emerging crisis response programs.

Planning Timeline

While some cities operated co-responder models for years before moving to a non-police model, other cities are launching non-police models for the first time. Some cities engaged in extensive community engagement

processes while others launched programs quickly and plan to collect feedback for future iterations of their program.

For instance, Denver had a co-responder model from 2016-2020 and launched the STAR program in 2020 for an initial six-month pilot. The program was launched very quickly in 2020, and then it held community forums to hear from community members for input on the expansion. In Chicago, planning began in the summer of 2019 and the mental health advisory commission developed recommendations in October 2019, then planning and funding continued throughout the summer of 2020, with the program launched in the summer of 2021 (two years after initial program planning began).

New York City's B-HEARD program was originally announced in November 2020 with an initial launch target of February 2021, though the launch was delayed until June 2021 (eight months later). San Francisco's Street Crisis Response Team began planning in July 2020 and launched with one team in November 2020 (five months later); the program added a second team and additional hours in January 2021, added four more teams in March 2021, and integrated the local Office of Coordinated Care team for follow-up and linkages in April 2021 (all over a span of four months); the City of San Francisco wanted to move quickly due to its budgeting timeline so it did not conduct much initial community engagement, but rather expected the program design to be an iterative process with future opportunities for community input and evaluation. Additionally, for many pilot crisis response programs, when they are able to scale their services and hire more staff, then they plan to expand their geographical footprints.

Community Engagement

Community engagement is an invaluable element of program design and evaluation that leverages the expertise of the local community members directly impacted by these services. Community engagement activities are conducted to include the perspectives of potential service recipients, existing consumers of the behavioral health and crisis systems, existing coalitions, and/or local community-based service providers in the development and implementation of crisis response programs.

Cities may face barriers in hearing from community members that are the most structurally marginalized, so engaging existing coalitions and networks can support more equitable and targeted outreach. For instance, in Chicago, Sacramento, and Oakland, program planners worked with credible messengers that were connected to networks that the cities were not connected to, such as a teen health council, street outreach teams, homeless advocacy organizations, and disability rights collectives. There was a focus especially on working with mutual aid collectives and other underground groups that do not receive city funding, including voices that may otherwise be neglected in government spaces. This level of outreach and intentionality is essential because, historically, government institutions and other structures have prevented

the full and meaningful engagement of people of color, working class and cash-poor people, immigrants and undocumented people, people with disabilities, people who are cognitively diverse, LGBTQ+ people, and other structurally marginalized people. Engaging community members that are most directly impacted by crisis response programs, such as unsheltered people, will lead to feedback that is informed by direct lived experiences with the prior and existing programs in a given community. Additionally, prioritizing the engagement, participation, and recommendations of community members that are most harmed by existing institutions - such as the disproportionate rates of police violence against people of color[16] - will ensure that systems of inequity are not reproduced by a crisis response program. Instead, intentional community engagement can support the program to address existing structural inequities.

Community engagement can inform program planning, program implementation, and program evaluation in unique ways. When planning for a crisis response program, community engagement can be used to survey existing needs, collect input on priorities, and engage hard-to-reach consumers. To hear directly from community members, Chicago interviewed 100 people across the city to ask about their service needs and how to implement a co-responder or alternative crisis response model. Denver targeted specific community stakeholder groups when collecting feedback for its program design, including perspectives from residents with lived experience, community activists for reimagining policing, a Latinx clinic, and a needle exchange program.

When implementing a crisis response program, engaging the community can identify opportunities for program improvement in real-time and promote community education about the program's services and partners. To collect feedback on key components of its model, Portland worked with a local university to send a questionnaire to service recipients. Denver prioritized community education by working with Business Improvement Districts (BIDs) to educate them on appropriate and inappropriate times to call 911 and how to more effectively and compassionately engage with unsheltered neighbors. Denver also worked to build trust with local CBOs to increase their engagement of the STAR crisis response team. Such community engagement can improve program implementation by increasing community awareness of the program, clarifying existing barriers for community members, and modifying service provision processes and priorities on an ongoing basis.

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[16] Edwards, F., Lee, H., & Esposito, M. (2019). Risk of being killed by police use of force in the United States by age, race-ethnicity, and sex. *Proceedings of the National Academy of Sciences of the United States of America (PNAS), 116*(34), 16793-16798. **https://www.pnas.org/content/116/34/16793**

Lessons Learned

As cities have begun planning, launching, and iterating on a variety of crisis response program models, they shared key lessons learned and recommendations for new cities considering implementing non-police crisis response programs.

Community members are essential sources of knowledge: Co-creating a crisis response model with community members that have directly experienced the crisis system will make the program more accessible and utilized.

Community engagement requires time: Build the engagement and planning time into the overall program development approach and timeline.

Use a pilot approach: Test, modify, and expand specific aspects of each crisis response model based on program successes, challenges, and consumer feedback.

Build trust across the network: Cities must build trust across city agencies and local CBOs to successfully launch and implement a crisis response program.

The 911 dispatch system is complex: Successful implementation of a crisis response program requires sufficient planning, time/resources investment, and buy-in for revising 911 call determination and dispatch processes.

Look to the future: While alternative models are currently focused on crisis response, future models could also support a population's holistic health outcomes and redefine what "safety" means in a community.

Community members are essential sources of knowledge.

Program representatives that spoke with RDA emphasized the many considerations that programs must make to ensure a program is utilized and accessible to community members. The interviewed programs emphasized the importance of co-creating programs with community members because community members have experienced the existing crisis response options, know where the gaps exist, and may have already implemented or witnessed community-based short-term solutions that should directly inform program design. Cities explained that creating a program or model that does not appeal to the consumer, especially in terms of the involvement and presence of law enforcement, will decrease

the reach and impact of the program. Community members must trust the program if they are going to call and engage in services. For example, because they understood that a significant barrier was that the general public was not confident that they could call 911 to engage a non-police response to a mental health or related crisis, the San Francisco's Street Crisis Response Teams have done significant outreach at community events and presentations at CBOs to build relationships and trust.

Community engagement requires time.

Learning from the community requires time, so plans for community engagement should be part of any new program's overall timeline and approach. For example, after their initial implementation began, Denver's STAR teams learned that there is a need to expand their program with multilingual teams, which they have since been effective in making progress towards achieving this. It has been a part of the STAR program's process to prioritize program needs as they arise while planning for expansion.

Use a pilot approach.

Cities also recommended using a pilot approach so that the model can evolve and expand over time. For example, Chicago piloted two crisis response teams with a CIT-officer and piloted two teams without a CIT-officer to determine the role and efficacy of the CIT-officer in a crisis response. New York City designed their pilot to focus on one zone (a geographic subsection of a borough) before broadening the pilot to more of the city. A pilot approach allows a city to learn from implementation successes and challenges, hear from service recipients, and generate buy-in from potentially hesitant stakeholders.

Build trust across the network.

Cities elevated that building trust across city departments and with CBOs was an essential component of their processes. Cities recognize the different cultures and priorities across city departments and agencies as well as CBOs and volunteers. Within a local government, framing this work as a health response helps to align all partners on their shared values. Moreover, emphasizing to the local police departments that taking a responsibility off their plate is a benefit to them, which may help them to see the crisis response teams as assets and resources to them. Additionally, while bringing onboard internal (i.e., city departments and agencies) stakeholders to the table, it is important to ensure that they each have the appropriate degree of weight in decision making for the program. For example, New York City emphasized that law enforcement should not have an imbalance in controlling the conversation or

decisions. Programs also shared examples of opportunities to build trust across staff members: San Francisco's Street Crisis Response Team used all-team debriefs to strengthen communication and establish processes; and Canada's REACH Edmonton used data on their program and outcomes to promote accountability between providers. Ultimately, building and sustaining trust across a network of crisis response teams, first responders, and law enforcement agencies is a type of role that the central coordinating governance structure of a crisis response system should aim to lead and support.

The 911 dispatch system is complex.

The 911 dispatch component of a crisis response model is complex and requires effective collaboration for successful implementation. New York City felt that the dispatch and deployment components of its B-HEARD program took the most time to design well (e.g., diagramming calls, finding existing data), even though the 911 data infrastructure already existed. Similarly, Los Angeles' Department of Mental Health found the call diversion process and decision-making to be the most challenging aspect to align across departments. By being aware of this hurdle from the beginning, a new program can allocate sufficient time and resources as well as identify strategic personnel to support the development of this important component of any crisis response program.

Look to the future.

Finally, cities offered that they are only in their first steps of a longer process of designing alternative models of care in their communities. Planning for a program's next steps can make the initial pilots even more successful and support the transition to future iterations. For instance, Portland's Street Response program is primarily focused on low-acuity crises, though there is a need for a non-police response that can respond to higher acuity calls, including incidences with weapons, in order to achieve Portland's aim of reducing police violence. Mental Health First emphasized that an armed officer does not necessarily provide security and safety to bystanders, providers, or consumers, and so alternative crisis response models are countering a larger system of socialization around notions of safety and the role of 911 in a community. Additionally, these models are operating within larger mental health response systems that must work together to ensure fewer community members are going into crisis in the first place. Programs should always be considering how alternative models of care can support individuals from entering into crises, too. Denver's STAR program shared that they have numerous opportunities for prevention efforts, such as proactive response after encampment sweeps, checking in with consumers in high visibility areas even if there is not a call there, and proactively connecting people to services. By keeping an open mind for what a more holistic crisis response system could look like in their future, cities can plan for their present day,

early-stage pilot programs to be a part of their evolving and innovative models of care.

Appendices

Appendix A. SAMHSA's National Guidelines for Behavioral Health Crisis Care - Best Practice Toolkit Executive Summary[17]

The *National Guidelines for Crisis Care – A Best Practice Toolkit* advances national guidelines in crisis care within a toolkit that supports program design, development, implementation and continuous quality improvement efforts. It is intended to help mental health authorities, agency administrators, service providers, state and local leaders think through and develop the structure of crisis systems. The toolkit includes distinct sections for:

- ✓ Defining national guidelines in crisis care;
- ✓ Implementing care that aligns with national guidelines; *and*
- ✓ Evaluating alignment of systems to national guidelines.

Given the ever-expanding inclusion of the term "crisis" by entities describing service offerings that do not truly function as no-wrong-door safety net services, we start by defining what crisis services are and what they are not. Crisis services are for **anyone, anywhere and anytime.** Crisis services include (1) crisis lines accepting all calls and dispatching support based on the assessed need of the caller, (2) mobile crisis teams dispatched to wherever the need is in the community (not hospital emergency departments) and (3) crisis receiving and stabilization facilities that serve everyone that comes through their doors from all referral sources. These services are for **anyone, anywhere and anytime.**

With non-existent or inadequate crisis care, costs escalate due to an overdependence on restrictive, longer-term hospital stays, hospital readmissions, overuse of law enforcement and human tragedies that result from a lack of access to care. Extremely valuable psychiatric inpatient assets are over-burdened with referrals that might be best-supported with less intrusive, less expensive services and supports. In too many communities, the "crisis system" has been unofficially handed over to law enforcement; sometimes with devastating outcomes. The current approach to crisis care is patchwork and

[17] Substance Abuse and Mental Health Services Administration (SAMHSA). (2020). *National Guidelines for Behavioral Health Crisis Care – Best Practice Toolkit Executive Summary*. https://www.samhsa.gov/find-help/implementing-behavioral-health-crisis-care & https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-services-executive-summary-02242020.pdf

delivers minimal treatment for some people while others, often those who have not been engaged in care, fall through the cracks; resulting in multiple hospital readmissions, life in the criminal justice system, homelessness, early death and even suicide.

A comprehensive and integrated crisis network is the first line of defense in preventing tragedies of public and patient safety, civil rights, extraordinary and unacceptable loss of lives, and the waste of resources. There is a better way. Effective crisis care that saves lives and dollars requires a systemic approach. This toolkit will delineate how to estimate the crisis system resource needs of a community, the number of individuals who can be served within the system, the cost of crisis services, the workforce demands of implementing crisis care and the community-changing impact that can be seen when services are delivered in a manner that aligns with this Best Practice Toolkit. Readers will also learn how this approach harnesses data and technology, draws on the expertise of those with lived experience, and incorporates evidence-based suicide prevention practices.

Core Services and Best Practices

The following represent the *National Guidelines for Crisis Care* essential elements within a **no- wrong-door** integrated crisis system:

1. **Regional Crisis Call Center**: Regional 24/7 clinically staffed hub/crisis call center that provides crisis intervention capabilities (telephonic, text and chat). Such a service should meet National Suicide Prevention Lifeline (NSPL) standards for risk assessment and engagement of individuals at imminent risk of suicide and offer quality coordination of crisis care in real-time;
2. **Crisis Mobile Team Response**: Mobile crisis teams available to reach any person in the service area in his or her home, workplace, or any other community-based location of the individual in crisis in a timely manner; *and*
3. **Crisis Receiving and Stabilization Facilities**: Crisis stabilization facilities providing short-term (under 24 hours) observation and crisis stabilization services to all referrals in a home-like, non-hospital environment.

In addition to the essential structural or programmatic elements of a crisis system, the following list of essential qualities must be "baked into" comprehensive crisis systems:

1. Addressing recovery needs, significant use of peers, and trauma-informed care;
2. "Suicide safer" care;
3. Safety and security for staff and those in crisis; *and*

4. Law enforcement and emergency medical services collaboration.

Regional Crisis Call Hub Services – *Someone To Talk To*

Regional, 24/7, clinically staffed call hub/crisis call centers provide telephonic crisis intervention services to all callers, meet National Suicide Prevention Lifeline (NSPL) operational standards regarding suicide risk assessment and engagement and offer quality coordination of crisis care in real-time. Ideally, these programs will also offer text and chat options to better engage entire communities in care. Mental health, substance use and suicide prevention lines must be equipped to take all calls with expertise in delivering telephonic intervention services, triaging the call to assess for additional needs and coordinating connections to additional support based on the assessment of the team and the preferences of the caller.

Minimum Expectations to Operate a Regional Crisis Call Service

1. Operate every moment of every day (24/7/365);
2. Be staffed with clinicians overseeing clinical triage and other trained team members to respond to all calls received;
3. Answer every call or coordinate overflow coverage with a resource that also meets all of the minimum crisis call center expectations defined in this toolkit;
4. Assess risk of suicide in a manner that meets NSPL standards and danger to others within each call;
5. Coordinate connections to crisis mobile team services in the region; *and*
6. Connect individuals to facility-based care through warm hand-offs and coordination of transportation as needed.

Best Practices to Operate Regional Crisis Call Center

To fully align with best practice guidelines, centers must meet the minimum expectations and:

1. Incorporate Caller ID functioning;
2. Implement GPS-enabled technology in collaboration with partner crisis mobile teams to more efficiently dispatch care to those in need;
3. Utilize real-time regional bed registry technology to support efficient connection to needed resources; *and*
4. Schedule outpatient follow-up appointments in a manner synonymous with a warm handoff to support connection to ongoing care following a crisis episode.

To align with National Suicide Prevention Lifeline (NSPL) operational standards, centers must:

1. Practice **active engagement** with callers and make efforts to establish sufficient rapport so as to promote the caller's collaboration in securing his/her own safety;

2. Use the **least invasive intervention** and consider involuntary emergency interventions as a last resort, except for in circumstances as described below;
3. Initiate life-saving services for attempts in progress – in accordance with guidelines that do not require the individual's consent to initiate medically necessary rescue services;
4. Initiate active rescue to secure the immediate safety of the individual at risk if the caller remains unwilling and/or unable to take action to prevent his/her suicide and remains at imminent risk;
5. Practice active engagement with persons calling on behalf of someone else ("third-party callers") towards determining the least invasive, most collaborative actions to best ensure the safety of the person at risk;
6. Have supervisory staff available during all hours of operations for timely consultation in determining the most appropriate intervention for any individual who may be at imminent risk of suicide; *and*
7. Maintain caller ID or other method of identifying the caller's location that is readily accessible to staff.

True regional crisis call center hub services that offer air traffic control-type functioning are essential to the success of a crisis system. Cracks within a system of care widen when individuals experience interminable delays in access to services which are often based on an absence of:

1. Real-time coordination of crisis and outgoing services; *and*
2. Linked, flexible services specific to crisis response; namely mobile crisis teams and crisis stabilization facilities.

Mobile Crisis Team Services – *Someone To Respond*

Mobile crisis team services offering community-based intervention to individuals in need wherever they are; including at home, work, or anywhere else in the community where the person is experiencing a crisis. For safety and optimal engagement, two person teams should be put in place to support emergency department and justice system diversion. EMS services should be aware and partner as warranted.

Minimum Expectations to Operate a Mobile Crisis Team Services

1. Include a licensed and/or credentialed clinician capable to assessing the needs of individuals within the region of operation;
2. Respond where the person is (home, work, park, etc.) and not restrict services to select locations within the region or particular days/times; *and*
3. Connect to facility-based care as needed through warm hand-offs and coordinating transportation when and only if situations warrants transition to other locations.

Best Practices to Operate Mobile Crisis Team Services

To fully align with best practice guidelines, teams must meet the minimum expectations and:

1. Incorporate peers within the mobile crisis team;
2. Respond without law enforcement accompaniment unless special circumstances warrant inclusion in order to support true justice system diversion;
3. Implement real-time GPS technology in partnership with the region's crisis call center hub to support efficient connection to needed resources and tracking of engagement; *and*
4. Schedule outpatient follow-up appointments in a manner synonymous with a warm handoff in order to support connection to ongoing care.

Essential functions of mobile crisis services include:

- Triage/screening, including explicit screening for suicidality;
- Assessment;
- De-escalation/resolution;
- Peer support;
- Coordination with medical and behavioral health services; *and*
- Crisis planning and follow-up.

Crisis Receiving and Stabilization Services – *A Place to Go*

Crisis receiving and stabilization services offer the community a no-wrong-door access to mental health and substance use care; operating much like a hospital emergency department that accepts all walk-ins, ambulance, fire and police drop-offs. The need to say yes to mental health crisis referrals, including working with persons of varying ages (as allowed by facility license) and clinical conditions (such as serious emotional disturbance, serious mental illness, intellectual and developmental disabilities), regardless of acuity, informs program staffing, physical space, structure and use of chairs or recliners in lieu of beds that offer far less capacity or flexibility within a given space. It is important to fund these facility-based programs so they can deliver on the commitment of never rejecting a first responder or walk-in referral in order to realize actual emergency department and justice system diversion. If an individual's condition is assessed to require medical attention in a hospital or referral to a dedicated withdrawal management (i.e., referred to more commonly and historically as detoxification) program, it is the responsibility of the crisis receiving and stabilization facility to make those arrangements and not shift that responsibility to the initial referral source (family, first responder or mobile team). Law enforcement is not expected to do the triage or assessment for the crisis system and it is important that those lines never become blurred.

Minimum Expectations to Operate a Crisis Receiving and Stabilization Service

1. Accept all referrals;
2. Not require medical clearance prior to admission but rather assessment and support for medical stability while in the program;
3. Design their services to address mental health and substance use crisis issues;
4. Employ the capacity to assess physical health needs and deliver care for most minor physical health challenges with an identified pathway in

order to transfer the individual to more medically staffed services if needed;

5. Be staffed at all times (24/7/365) with a multidisciplinary team capable of meeting the needs of individuals experiencing all levels of crisis in the community; including:
    a. Psychiatrists or psychiatric nurse practitioners (telehealth may be used)
    b. Nurses
    c. Licensed and/or credentialed clinicians capable of completing assessments in the region; *and*
    d. Peers with lived experience similar to the experience of the population served.
6. Offer walk-in and first responder drop-off options;
7. Be structured in a manner that offers capacity to accept all referrals, understanding that facility capacity limitations may result in occasional exceptions when full, with a no rejection policy for first responders;
8. Screen for suicide risk and complete comprehensive suicide risk assessments and planning when clinically indicated; *and*
9. Screen for violence risk and complete more comprehensive violence risk assessments and planning when clinically indicated.

Best Practices to Operate Crisis Receiving and Stabilization Services

To fully align with best practice guidelines, centers must meet the minimum expectations and:

1. Function as a 24 hour or less crisis receiving and stabilization facility;
2. Offer a dedicated first responder drop-off area;
3. Incorporate some form of intensive support beds into a partner program (could be within the services' own program or within another provider) to support flow for individuals who need additional support;
4. Include beds within the real-time regional bed registry system operated by the crisis call center hub to support efficient connection to needed resources; *and*
5. Coordinate connection to ongoing care.

The Role of the Psychiatrist/Psychiatric Nurse Practitioner

Psychiatrists and Psychiatric Nurse Practitioners serve as clinical leaders of the multi-disciplinary crisis team. Essential functions include ensuring clinical soundness of crisis services through evaluation of need, continued monitoring of care and crisis service discharge planning.

Essential Principles for Modern Crisis Care Systems

Best practice crisis care incorporates a set of core principles that must be systematically "baked in" to excellent crisis systems in addition to the core structural elements that are defined as essential for modern crisis systems. These essential principles and practices are:

1. Addressing Recovery Needs,

2. Significant Role for Peers,
3. Trauma-Informed Care,
4. *Zero Suicide*/Suicide Safer Care,
5. Safety/Security for Staff and People in Crisis *and*
6. Crisis Response Partnerships with Law Enforcement, Dispatch, and Emergency Medical Services.

Addressing Recovery Needs

Crisis providers must address the recovery needs of individuals and families to move beyond their mental health and substance use challenges to lead happy, productive and connected lives each and every day.

Implementation Guidance

1. *Commit to a no-force-first approach to quality improvement in care that is characterized by engagement and collaboration.*
2. *Create engaging and supportive environments that are as free of barriers as possible. This should include eliminating Plexiglas from crisis stabilization units and minimal barriers between team members and those being served to support stronger connections.*
3. *Ensure team members engage individuals in the care process during a crisis. Communicate clearly regarding all options clearly and offer materials regarding the process in writing in the individual's preferred language whenever possible.*
4. *Ask the individual served about their preferences and do what can be done to align actions to those preferences.*
5. *Help ensure natural supports and personal attendants are also part of the planning team, such as with youth and persons with intellectual and developmental disabilities.*
6. *Work to convert those with an involuntary commitment to voluntary so they are invested in their own recovery.*

Significant Role for Peers

A transformative element of recovery-oriented care is to fully engage the experience, capabilities and compassion of people who have experienced mental health crises. Including individuals with lived mental health and substance use disorder experience (peers) as core members of a crisis team supports engagement efforts through the unique power of bonding over common experiences while adding the benefits of the peer modeling that recovery is possible.

Implementation Guidance

1. *Hire credentialed peers with lived experience that reflect the characteristics of the community served as much as possible. Peers should be hired with attention to common characteristics such as gender, race, primary language, ethnicity, religion, veteran status, lived experiences and age.*

2. *Develop support and supervision that aligns with the needs of your program's team members.*
3. *Emphasize engagement as a fundamental pillar of care that includes peers as a vital part of a crisis program's service delivery system. This should include (1) integrating peers within available crisis line operations, (2) having peers serve as one of two mobile team members and (3) ensuring a peer is one of the first individuals to greet an individual admitted to a crisis stabilization facility.*

Trauma-Informed Care

The great majority of individuals served in mental health and substance use services have experienced significant interpersonal trauma. Mental health crises and suicidality often are rooted in trauma. These crises are compounded when crisis care involves loss of freedom, noisy and crowded environments and/or the use of force. These situations can actually re-traumatize individuals at the worst possible time, leading to worsened symptoms and a genuine reluctance to seek help in the future.

On the other hand, environments and treatment approaches that are safe and calm can facilitate healing. Thus, we find that trauma-informed care is an essential element of crisis treatment. In 2014, SAMHSA set the following guiding principles for trauma-informed care:

1. Safety;
2. Trustworthiness and transparency;
3. Peer support and mutual self-help;
4. Collaboration and mutuality;
5. Empowerment, voice and choice; *and*
6. Ensuring cultural, historical and gender considerations inform the care provided.

Trauma-informed systems of care ensure these practices are integrated into service delivery. Developing and maintaining a healthy environment of care also requires support for staff, who may have experienced trauma themselves.

Implementation Guidance

1. *Incorporate trauma-informed care training into each team member's new employee orientation with refreshers delivered as needed.*
2. *Apply assessment tools that evaluate the level of trauma experienced by the individuals served by the crisis program and create action steps based on those assessments.*

Zero Suicide/Suicide Safer Care

Two transformational commitments must be made by every crisis provider in the nation: (1) adoption of suicide prevention as a core responsibility, and (2) commitment to dramatic reductions in suicide among people under care. These changes were adopted and advanced in the revised *National Strategy for Suicide*

Prevention (2012), specifically via a new Goal 8: "Promote suicide prevention as a core component of health care services" (p. 51).

The following key elements of Zero Suicide or Suicide Safer Care are all applicable to crisis care:

1. Leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care, that includes survivors of suicide attempts and suicide loss in leadership and planning roles;
2. Developing a competent, confident, and caring workforce;
3. Systematically identifying and assessing suicide risk among people receiving care;
4. Ensuring every individual has a pathway to care that is both timely and adequate to meet his or her needs and includes collaborative safety planning and a reduction in access to lethal means;
5. Using effective, evidence-based treatments that directly target suicidal thoughts and behaviors;
6. Providing continuous contact and support; especially after acute care; *and*
7. Applying a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk.

Safety/Security for Staff and People in Crisis

Safety for both individuals served and staff is a foundational element for all crisis service settings. Crisis settings are also on the front lines of assessing and managing suicidality and possibly violent thoughts or aggressive behaviors, issues with life and death consequences. While ensuring safety for people using crisis services is paramount, the safety for staff cannot be compromised. Keys to safety and security in crisis delivery settings include:

- Evidence-based and trauma-informed crisis training for all staff;
- Role-specific staff training and appropriate staffing ratios to number of clients being served;
- A non-institutional and welcoming physical space and environment for persons in crisis, rather than Plexiglas "fishbowl" observation rooms and keypad-locked doors. This space must also be anti-ligature sensitive and contain safe rooms for people for whom violence may be imminent;
- Established policies and procedures emphasizing "no force first" prior to implementation of safe physical restraint or seclusion procedures;
- Pre-established criteria for crisis system entry;
- Strong relationships with law enforcement and first responders; *and*
- Policies that include the roles of clinical staff (and law enforcement if needed) for management of incidents of behavior that places others at risk.

Providers must establish environments that are safe for those they serve as well as their own team members who are charged with delivering high quality crisis care that aligns with best practice guidelines. The keys to safety and security for

home visits by mental health staff include:

- No mental health crisis outreach worker will be required to conduct home visits alone.
- Employers will equip mental health workers who engage in home visits with a communication device.
- Mental health workers dispatched on crisis outreach visits will have prompt access to any information available on history of dangerousness or potential dangerousness of the client they are visiting.

Implementation Guidance

1. *Commit to a no-force-first approach to care.*
2. *Monitor, report and review all incidents of seclusion and restraint with the goal of minimizing the use of these interventions.*
3. *Remember that barriers do not equal safety. The key to safety is engagement and empowerment of the individual served while in crisis.*
4. *Offer enough space in the physical environment to meet the needs of the population served. A lack of space can elevate anxiety for all.*
5. *Incorporate quiet spaces into your crisis facility for those who would benefit from time away from the milieu of the main stabilization area.*
6. *Engage your team members and those you serve in discussions regarding how to enhance safety within the crisis program.*

Law Enforcement and Crisis Response—An Essential Partnership

Law enforcement agencies have reported a significant increase in police contacts with people with mental illness in recent years. Some involvement with mental health crises is inevitable for police. Police officers may (1) provide support in potentially dangerous situations when the need is assessed or (2) make warm hand-offs into crisis care if they happen to be first to engage.

In many communities across the United States, the absence of sufficient and well-integrated mental health crisis care has made local law enforcement the *de facto* mental health mobile crisis system. This is unacceptable and unsafe. The role of local law enforcement in addressing emergent public safety risk is essential and important. With good mental health crisis care in place, the care team can collaborate with law enforcement in a fashion that will improve both public safety and mental health outcomes. Unfortunately, well-intentioned law enforcement responders to a crisis call can escalate the situation solely based on the presence of police vehicles and armed officers that generate anxiety for far too many individuals in a crisis.

Implementation Guidance

1. *Have local crisis providers actively participate in Crisis Intervention Team training or related mental health crisis management training sessions.*

2. *Incorporate regular meetings between law enforcement and crisis providers, including EMS and dispatch, into the schedule so these partners can work to continuously improve their practices.*
3. *Include training on crisis provider and law enforcement partnerships in the training for both partner groups.*
4. *Share aggregate outcomes data such as numbers served, percentage stabilized and returned to the community and connections to ongoing care.*

Psychiatric Advance Directives

A psychiatric or mental health advance directive (PAD) is a legal tool that allows a person with mental illness to state their preferences for treatment in advance of a crisis. They can serve as a way to protect a person's autonomy and ability to self-direct care. Crisis providers are expected to always seek to understand and implement any existing PAD that has been developed by the individual during the evaluation phase and work to ensure the individual discharges from crisis care with an updated and accurate psychiatric advance directive whenever possible. PAD creates a path to express treatment preferences and identify a representative who is trusted and legally empowered to make healthcare decisions on medications, preferred facilities, and listings of visitors.

Funding Crisis Care

The full *Crisis Services Best Practice Toolkit* document contains specific strategies on how a community can fund each of the core crisis system elements in single and multiple-payer environments. Additionally, recommendations on service coding already being reimbursed by Medicaid in multiple states are made available; including the use of *HCPCS code H2011 Crisis Intervention Service per 15 Minutes* for mobile crisis services and *S9484 Crisis Intervention Mental Health Services per Hour* or *S9485 Crisis Intervention Mental Health Services per Diem* for crisis receiving and stabilization facility services.

Training and Supervision

Many members of the crisis services delivery team are licensed mental health and substance use professionals operating within the scope of their license and training with supervision delivered in a manner consistent with professional expectations of the licensing board. Licensed professionals are expected to strengthen their skills and knowledge through ongoing CEU and CME professional advancement opportunities focused on improving team members' ability to deliver crisis care.

Providers also incorporate non-licensed individuals within the service delivery

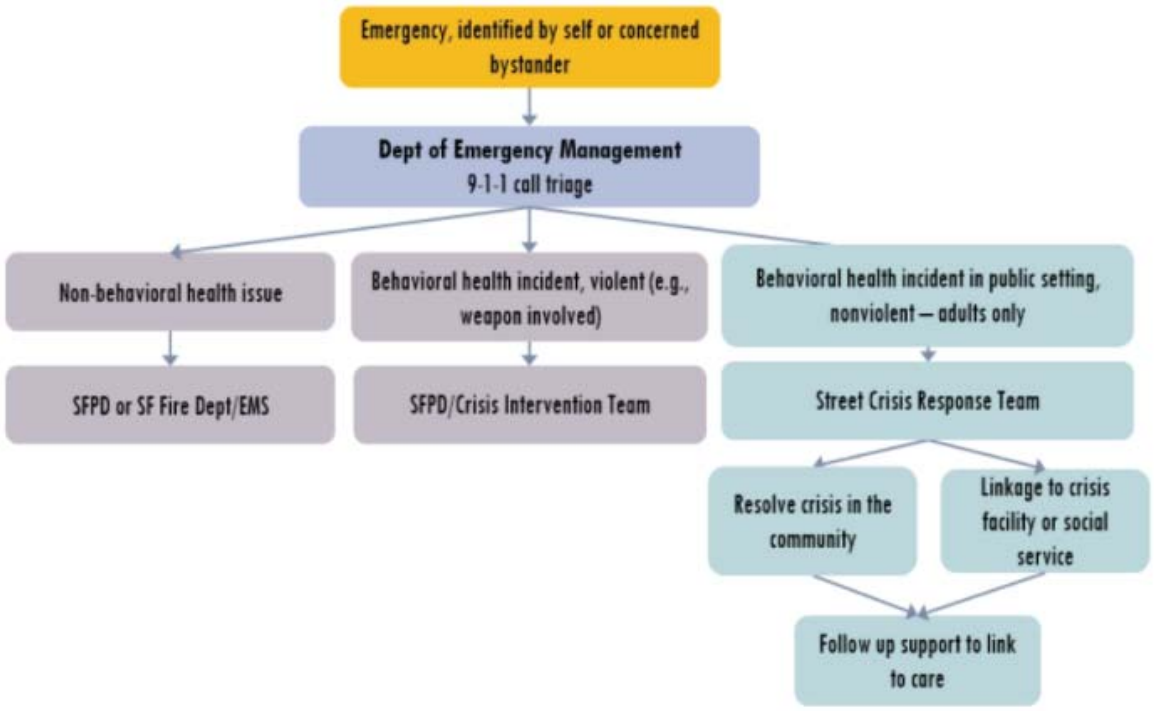
team; creating the need for additional training and supervision to ensure services are delivered in a manner that advances positive outcomes for those engaged in care. Verification of skills and knowledge of non-professional staff is essential to maintaining service delivery standards within a crisis program; including the incorporation of ongoing supervision with licensed professionals available on site at all times. Supervision and the verification of skills and knowledge shall include, but is not limited to, active engagement strategies, trauma-informed care, addressing recovery needs, suicide-safer care, community resources, psychiatric advance directives and role-specific tasks.

Conclusion

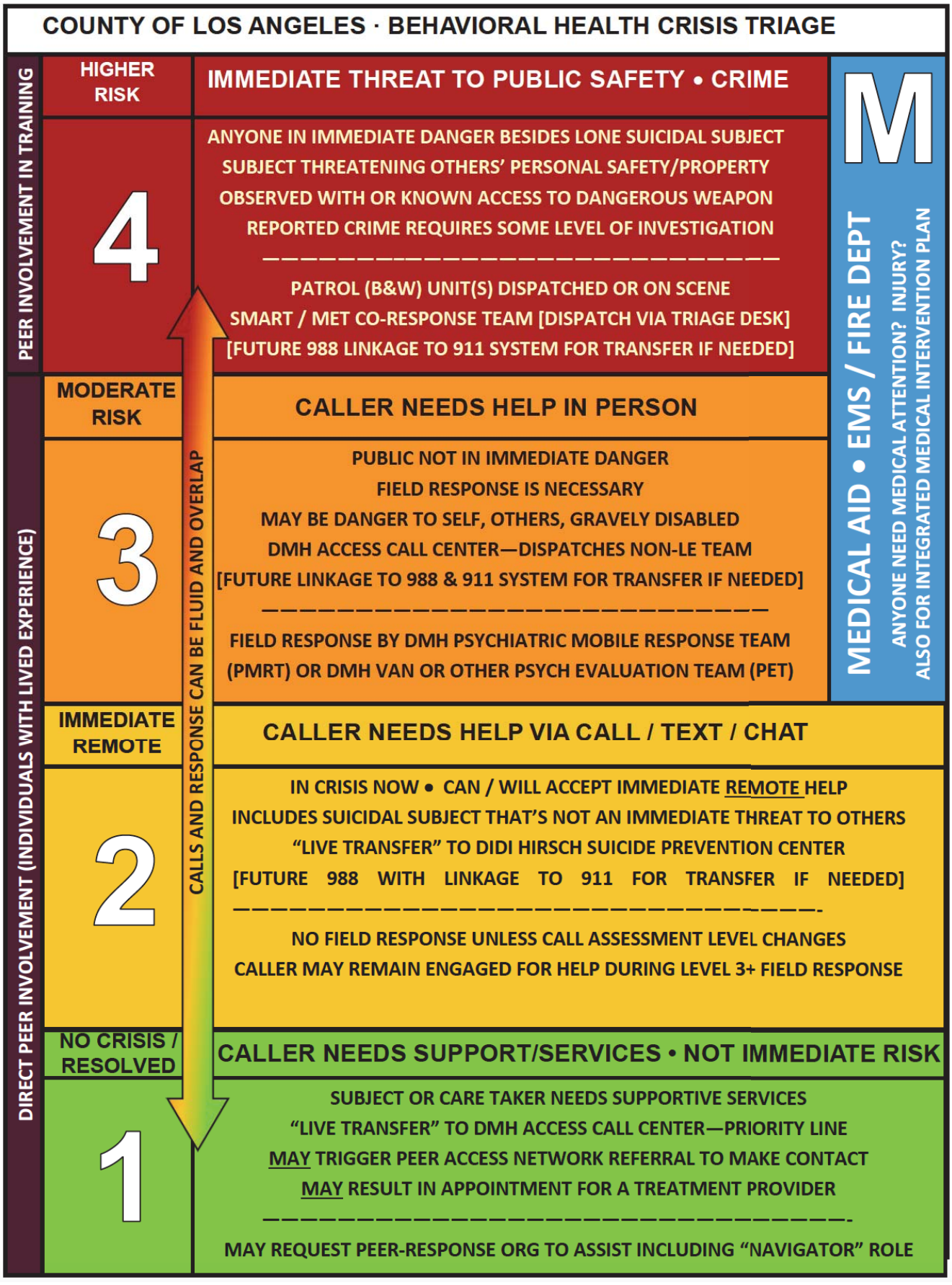
Crisis services must be designed to serve **anyone, anywhere and anytime**. Communities that commit to this approach and dedicate resources to address the community need decrease psychiatric boarding in emergency departments and reduce the demands on the justice system. These two benefits translate into better care, better health outcomes and lower costs to the community. The *National Guidelines for Crisis Care – A Best Practice Toolkit* delivers a roadmap that can be used to truly make a positive impact to communities across the country.

Appendix B. Sample Outlines of Types of Scenarios for Crisis Response Teams

Appendix B-1. County and City of San Francisco's Crisis Response



Appendix B-2. County of Los Angeles' Behavioral Health Crisis Triage



Appendix C. Crisis Response Programs Researched by RDA – Summary of Key Components

Program	Dispatch	Types of calls	Hours of operation	Crisis team staff	Vehicles	Follow-up process
Albuquerque Community Safety Department – *Albuquerque, NM*	911	Mental health, inebriation, homelessness, addiction	TBD	Clinicians or peers	TBD	TBD
B-HEARD (the Behavioral Health Emergency Assistance Response Division) – *New York, NY*	911 dispatch	Mental health	Daily 16 hours per day	2 EMTs or paramedics + social worker	Non-transport vehicles	Connect with services if transported; heat team does follow-up (clinician and peer for follow-up connection to services)
Boston Police Department's Co-Responder Program **– *Boston, MA***	911 dispatch	Mental health crisis	Unknown	Co-responder (police + clinician)	Police car	Unknown
Crisis Assistance Helping Out On The Streets (CAHOOTS) – *Eugene, OR*	911 calls dispatched on radio	Non-emergency calls	24/7	Unlicensed crisis worker and EMT or paramedic	3 vans with logo	Not currently part of services
Crisis Assessment & Transport Team (CATT) – *Alameda County, CA*	911 dispatch	Mental health	Daily 7am-12am	Licensed clinician + EMT, co-responding with police	Unmarked vehicles, barrier, custom locks and windows, locked storage cabinets	Unknown
Community Paramedicine – *California (statewide)*	911 dispatch	Non-emergency health and mental health calls	Unknown	Paramedics	Unknown	Unknown
Crisis Call Diversion Program (CCD) – *Houston, TX*	911 dispatch	Non-emergency mental and behavioral health calls	Daily, morning and evening shifts	Mental health professional tele-counselors at 911 call center	N/A	Unknown

Program	Dispatch	Types of calls	Hours of operation	Crisis team staff	Vehicles	Follow-up process
Crisis Now – *National model (via SAMHSA)*	Regional crisis call hub	Mental health	24/7	Licensed clinician + behavioral health specialist	Unmarked van	Program staff follows up to ensure connection to a resource
Crisis Response Pilot – *Chicago, IL*	911 dispatch	Mental health	M-F 9:30-5:30	Paramedic, crisis counselor, CIT officer, peer recovery coach	2 vans	Unknown
Crisis Response Unit – *Olympia, WA*	911 or alternate number	Mental health, homelessness	Daily 7am-9pm	Nurse + behavioral health specialist	Van owned by the City	Repeat clients get referred to peer navigation program (Familiar Faces)
Cuyahoga County Mobile Crisis Team – *Cuyahoga County, Ohio*	National Suicide Prevention Hotline	Mental health	24/7	Licensed clinicians	Unknown	Unknown
Department of Community Response – *Sacramento, CA*	911 or alternate number	Mental health, homelessness, youth and family crisis, substance use	24/7	Social workers	6 vans	CBO partner will provide connection to longer term care and follow up services
Department of Community Solutions and Public Safety – *Ithaca, NY*	TBD	Non-violent calls	TBD	Unarmed first responders	TBD	TBD
Downtown Emergency Service Center (DESC) Mobile Crisis Team – *King County, WA*	911 dispatch	Mental health, substance use	24/7	Mental health professional	Unknown	Unknown

Program	Dispatch	Types of calls	Hours of operation	Crisis team staff	Vehicles	Follow-up process
Expanded Mobile Crisis Outreach Team (EMCOT) – *Austin, TX*	911 or alternate number	Mental health	24/7	Field staff: two person teams of clinicians Call center staff: mental health professionals	Unmarked vehicles	Post-crisis services available for up to 3 months after initial contact
Georgia Crisis & Access Line (GCAL) – *Georgia (statewide)*	Alternate number, app	Non-emergency mental health, substance use	24/7	Mental health professionals	Unknown	Unknown
Los Angeles County Department of Mental Health - ACCESS Center – *Los Angeles County, CA*	Alternate number	Mental health	24/7	Unknown	Unknown	Unknown
Los Angeles County Department of Mental Health - Co-Response Program – *Los Angeles County, CA*	911 dispatch	Emergency mental health	Unknown	Co-responder (police + clinician)	Police car	Unknown
Los Angeles County Department of Mental Health - Psychiatric Mobile Response Team (PMRT) – *Los Angeles County, CA*	Alternate number	Mental health crises	Unknown	Psychiatric mobile response team	Unknown	Unknown
Mobile Assistance Community Responders of Oakland (MACRO) – *Oakland, CA*	911 dispatch	Non-emergency calls	24/7	Unlicensed community member + EMT	Vehicle with radios, mobile data terminal, cell phones	Community Resource Specialist to connect to resources
Mental Health Acute Assessment Team (MHAAT) – *Sydney, Australia*	Ambulance Control Center	Acute mental health crises	Unknown	Paramedic + mental health nurse	Ambulance	Contacted within 3 days, follow up with referral facility
Mental Health First / Anti-Police Terror Project – *Sacramento and Oakland, CA*	Alternate number, social media	Mental health, domestic violence, substance use	Fri-Sun 7pm-7am	Peer first responders	Use personal vehicles and meet at the scene; have an RV with supplies	Have relationship with CBOs, staff work to get folks into longer term services
Mental Health Mobile Crisis Team (MHMCT) – *Nova Scotia, Canada*	911 dispatch	Mental health	24/7	Co-responder (police + clinician) and telephone clinician support	Unknown	Unknown

Program	Dispatch	Types of calls	Hours of operation	Crisis team staff	Vehicles	Follow-up process
Mobile Crisis Assistance Team (MCAT) – *Indianapolis, IN*	911 dispatch	Mental health, substance use	M-F, not after hours or overnight	Co-responder (police + clinician + paramedics)	Unknown	Conduct follow up visits to encourage connection to care
Mobile Crisis Rapid Response Team (MCRRT) – *Hamilton, Ontario, Canada*	911 dispatch	Mental health	Unknown	Co-responder (CIT-trained police + clinician)	Police car	Unknown
Mobile Emergency Response Team for Youth (MERTY) – *Santa Cruz, CA*	Alternate number	Mental health calls for youth	M-F 8am-5pm	Clinician + family specialist	Van with wheelchair lift, comfortable chairs, TV, snacks	Continue to provide services until patient connected with long-term services
Mobile Evaluation Team (MET) – *East Oakland, CA*	911 or alternate number	Mental health	Mon-Thurs 8am-3:30pm	Co-responder (1-2 mental health clinicians + police officer)	Unmarked police car	Unknown
Psykiatrisk Akut Mobilitet (PAM) Unit, the Psychiatric Emergency Response Team – *Stockholm, Sweden*	Alarm center	Acute risk of suicidal behavior	Daily 2pm-2am	2 psychiatric nurses and ambulance driver	Ambulance	Unknown
Police and Clinician Emergency Response (PACER) – *Australia (several locations)*	Dispatched by police	Mental health	Varies	Co-responder (police + clinician)	Unknown	Unknown
Portland Street Response – *Portland, OR*	911 or alternate number	Low-acuity mental health, substance use, welfare checks	M-F 10am-6pm	EMT and LCSW dispatched to scene; 2 CHWs called in for follow-up	Van with logo	CHWs connect to services; partnerships with CBOs for outreach in encampments
REACH 24/7 Crisis Diversion – *Edmonton, Alberta, Canada*	Alternate number (211)	Non-violent, non-emergency calls	24/7	2 crisis diversion workers	Have van to transport	Connector role for connection to long-term services

Program	Dispatch	Types of calls	Hours of operation	Crisis team staff	Vehicles	Follow-up process
Seattle Crisis Response Team – *Seattle, WA*	911 dispatch	Mental health, assault/threat/harassment, suspicious circumstance, disturbance	Unknown	Co-responder (CIT + clinician)	Unknown	Clinicians can follow up with clients
Supported Team Assisted Response (STAR) – *Denver, CO*	911 dispatch	Mental health, homelessness, substance use	M-F 10am-6pm	Mental health clinician (SW) + paramedic	Civilian van with amber lights, bucket seats on each side with standard front seat	Can hand off to case managers
Street Crisis Response Team (SCRT) – *San Francisco, CA*	911 calls dispatched on radio	Non-emergency mental health	Daily, 12 hours a day	Social worker/psychologist + paramedic + peer	Van with lights and sirens, currently using old fire department vehicles	Office of Care Coordination provides linkages to other services
Street Triage – *England (several locations)*	Emergency dispatch	Mental health	Varies	Mental health nurse	Unknown	Unknown
Therapeutic Transportation Pilot Program/Alternative Crisis Response – *Los Angeles City and County, CA*	911 dispatch	Mental health crisis	24/7	Mental health experts co-respond or take the lead on MH calls	Plan to have van for transports	Level 1 calls will be referred to non-crisis follow up services, folks can step down from crisis receiving to residential program
Toronto Crisis Response – *Toronto, Ontario, Canada*	TBD	Non-violent, non-emergency calls	TBD	Mental health professionals	TBD	TBD

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Tuesday, September 7, 2021 11:28 AM
To: Works-Wright, Jamie
Subject: FW: MHAB Executive Committee Meeting 9/9/2021
Attachments: MHAB Executive Committee Agenda 09-09-2021.pdf; Executive Committee Minutes 2021 08-12 UNAPPROVED.pdf

Please disregard the last email and read this one

Jamie Works-Wright
Consumer Liaison
Jworks-wright@cityofberkeley.info
510-423-8365 cl
510-981-7721 office

From: MHB Communications, ACBH <ACBH.MHBCommunications@acgov.org>
Sent: Friday, September 3, 2021 4:19 PM
Cc: MHB Communications, ACBH <ACBH.MHBCommunications@acgov.org>
Subject: MHAB Executive Committee Meeting 9/9/2021

Good afternoon,

Please find attached agenda/minutes and meeting information below for the MHAB Executive Committee Meeting on Thursday, 9/9/2021.

Please join my meeting from your computer, tablet or smartphone.
https://global.gotomeeting.com/join/985996269

You can also dial in using your phone.
United States: +1 (571) 317-3116

Access Code: 985-996-269

Join from a video-conferencing room or system.
Dial in or type: 67.217.95.2 or inroomlink.goto.com

Meeting ID: 985 996 269
Or dial directly: 985996269@67.217.95.2 or 67.217.95.2##985996269

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Asia Jenkins
Alameda County Behavioral Health Care Services
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Oakland, CA 94606-5300

Tel: (510) 567-8131
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QIC: 22711

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

Alameda County
Mental Health Advisory Board

Mental Health Advisory Board Agenda
Executive Committee

Thursday, September 9, 2021 ◊ 3:30 PM – 5:00 PM

This meeting will be conducted exclusively through videoconference and teleconference

https://global.gotomeeting.com/join/985996269

Teleconference: 1-571-317-3116, Access Code: 985-996-269

Committee Members:	**Lee Davis** *(Chair, District 5)* **Brian Bloom** *(District 4)*	**L.D. Louis** *(Vice Chair, District 4)* **Juliet Leftwich** *(District 5)*

3:30 PM **Call to Order** ..... Chair Lee Davis

3:30 PM **I. Roll Call**

3:35 PM **II. Approval of Minutes**

3:40 PM **III. Discussion Items**

A. Future Agenda Items for MHAB September, October and November Meetings
   a) Ad hoc committee Monitoring Framework and Data
   b) Elections
   c) Housing and Homelessness
   d) DOJ Report
   e) LPS return to local treatment issue
   f) Care First, Jail Last Committee Composition

B. BOS Presentation

C. Annual Retreat

D. Updated Calendar with new Adult Committee time

V. MHAB Staff Report

A. Annual Banquet Update
B. Website Update

4:55 PM **VI. Public Comment**

5:00 PM **VII. Adjournment**

Alameda County
Mental Health Advisory Board

Executive Committee UNAPPROVED Minutes
Thursday, August 12, 2021 ◊ 3:30 PM – 5:00 PM
2000 Embarcadero Cove, Suite 400, Oakland

Teleconference Meeting

Committee Members:	☒ **Lee Davis** *(Chair, District 5)*; ☒ **L.D. Louis** *(Vice-Chair, District 4)*; ☐ **Brian Bloom** *(District 4)*; ☒ **Juliet Leftwich** *(District 5)*; ☒ **Marsha McInnis** *(District 1)*
ACBH Staff:	☒ **Karyn Tribble** (*ACBH Director);* ☐ **James Wagner** (*ACBH Deputy Director)*; ☒ **Dainty Castro** *(Administrative Liaison)*; ☒ **Angelica Gums** *(Secretary II);* ☒ **Asia Jenkins** *(Office of the ACBH Director)*

Meeting called to order @ 3:30 PM by **Chair Lee Davis**.

ITEM	DISCUSSION	DECISION/ACTION
Roll Call	Roll Call completed.	
Approval of Minutes	Minutes approved.	
Discussion Items	A. Future Agenda Items for MHAB August, September, etc. Meeting Ideas a) DOJ Report The DOJ Report will continue to be discussed in the Criminal Justice Committee meeting. b) Incompetent to Stand Trial (IST) Program For discussion at an upcoming Criminal Justice Committee meeting. c) LPS return to local treatment issue It was previously reported that there is a committee forming at the state level and legislation. Would like to hear an update if there is a committee forming at the local level and any movement of the agency forming a committee.	

ITEM	DISCUSSION	DECISION/ACTION
	d) JIMHT Report follow-up Will be a report out and discussion at the August MHAB main meeting. Member Bloom Vice Chair Louis to gives background and report out on the JIMH Taskforce and final report.	Attach final JIMH report to August MHAB main meeting agenda.
	e) NAMI presentations (Adult Committee?) Presentation at September Adult Committee meeting.	
	f) Housing, Homelessness & SMI For discussion at an upcoming Adult Committee meeting.	
	g) Care First, Jail Last Committee Composition (Criminal Justice Committee?) Will be a discussion at the August MHAB main meeting on the committee composition. The current composition of this committee will be two appointees of the Health Committee drawn from the MHAB, Alameda Health Systems, East Bay Supportive Housing and the Mental Health Collaborative. It is very important that the MHAB discuss how the Board will interface with the Care First, Jails Last Committee. Vice Chair Louis has been asked to attend as DA representative when Nancy is unavailable to attend. It was discussed that Member Leftwich or Member Bloom could represent the MHAB on this committee. The current composition that was received by MHAB member was received from Decarcerate Alameda County. The Agency is working and are in discussions with the Board of Supervisors (BOS) to receive clarity around the composition, and since the agency will be leading the work want to be sure they are doing the work the BOS has charged the agency to do.	Attach resolution to MHAB main meeting agenda.
	B. ACBH Monitoring Framework (Ad Hoc Committee meeting 8/10/21 – 3:30pm) In the ad hoc committee, there is a focus on high utilizers definition. High utilizers can vary depending on the context. The JIMH definitions mentions episodes. The agency is currently looking at the definition and criteria for high utilizers. The agency looks at admission to inpatient treatment of	Chair Davis to give report out under Chair's report for August MHAB Main meeting.

ITEM	DISCUSSION	DECISION/ACTION
	PES, as one can have an episode that doesn't require a hospitalization or PES visit. The ad hoc committee will need the discuss admissions versus visits.	
	C. Elections Elections will be held at the MHAB main meeting in September. Will e-mail all MHAB members to solicit nominations for the upcoming election at the MHAB main meeting. Deadline to submit nominations will be Thursday, September 2nd at 12pm. Interested candidates can be given time at the September main meeting to address members.	Chair Davis to announce under the Chair's Report for August MHAB Main meeting. Angelica to support emailing all MHAB members. Will include under the Chair's Report.
	D. Bylaws Member Leftwich will continue to be the point of contact on the Bylaws. Next steps are to present at future BOS meeting for adoption of the bylaws by the Board of Supervisors.	Staff to send bylaws to L.D. for signature, once Lee's signature is added. Staff will draft board letter/ request date for future BOS meeting.
	E. Annual Report All MHAB members interested in receiving a hard copy can receive one. Will upload Annual report to new MHAB webpage. Chair Davis would like to schedule a presentation to the BOS at a future Health Committee Meeting. Currently, there are a few dates being considered. Planning and presentation can be discussed further at a future Exec Committee meeting.	Staff can send an email to members to confirm if they would like to receive a hard copy and confirm the delivery address to send report. Asia to send Annual Report to Sarina.
	F. Requests for ACBH Director Report Items Executive Committee members requested and would like an update on Glenn Dyer Jail, Safe Landing, budget update on the contract right sizing, and LPS. In the future, may want to look at the time allocated for the Director's Report.	

ITEM	DISCUSSION	DECISION/ACTION
MHAB Staff Report	A. Annual Banquet Update ACBH staff has contacted venue to cancel the October 14, 2021 reservation. Currently, all Thursdays in May 2022 are available to host the Annual Awards Banquet. Executive Committee discussed to tentatively schedule the banquet for Thursday, May 19, 2022. B. Website Update Website is still in progress. Planning to launch at the end of the month.	Asia will reach out to venue to reserve Thursday, May 19, 2022.
Public Comment	Public Comment was given.	
Adjournment	Adjourned at 5:00 PM	

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Wednesday, September 1, 2021 1:01 PM
To: Works-Wright, Jamie
Subject: FW: Berkeleyside article today on Santa Rita.

Please see information below

Jamie Works-Wright
Consumer Liaison
Jworks-wright@cityofberkeley.info
510-423-8365 cl
510-981-7721 office

From: boona cheema <boonache@aol.com>
Sent: Tuesday, August 31, 2021 2:20 PM
To: Works-Wright, Jamie <JWorks-Wright@cityofberkeley.info>
Subject: Berkeleyside article today on Santa Rita.

Please forward to entire commission

Alameda County agrees to overhaul mental health care in Santa Rita Jail (berkeleyside.org)

Alameda County jail’s mental health care would be overhauled under propo...

To settle a civil rights lawsuit, the sheriff’s office would be placed under court supervision for up to 6 years.

Berkeleyside

CRIME & SAFETY

Alameda County jail's mental health care would be overhauled under proposed lawsuit settlement

The agreement, which must still be approved by a federal judge, would place the sheriff's office under court supervision for up to 6 years, maybe longer.

By Scott Morris, Aug. 31, 2021, 8:50 a.m.

Outside Alameda County's Santa Rita Jail. File photo: Pete Rosos

Alameda County has agreed to a massive reform program that will remake how mental health care is provided in Santa Rita Jail in order to settle a class action lawsuit filed three years ago on behalf of jail detainees.

The terms of the 110-page proposed settlement were made public in court filings last week. Under the settlement, the Alameda County Sheriff's Office will be required to revamp its policies and procedures, hire new staff at the jail, build a new "therapeutic housing unit," and put new oversight structures in place. The draft agreement still must be approved by U.S. Magistrate Judge Nathanael Cousins, who is scheduled to hear the motion on Sept. 22.

If approved, the settlement could address many of the problems identified by the U.S. Department of Justice Civil Rights Division in a report released in April that showed Alameda County's system of mental health care violates the 8th and 14th Amendments to the Constitution and the Americans with Disabilities Act. While the Department of Justice's investigation of the county's mental health care system is separate from the jail lawsuit, the DOJ has been monitoring negotiations in the case. The DOJ will attempt to reach a separate settlement with the county before filing its own lawsuit. Having such extensive reforms in place already will likely contribute to such a settlement. But the DOJ's investigation faulted the county's entire system of mental health care, and the proposed class action settlement only covers issues in the jail.

Throughout the country, jails and prisons have become the de facto largest provider of mental health care as people without adequate treatment suffer psychological breakdowns that can lead to criminal behavior. The DOJ found that the problem was particularly acute in Alameda County, citing a lack of community resources and a much higher rate of involuntary psychiatric emergency holds than elsewhere in California.

Jeffrey Bornstein, a partner at Rosen Bien Galvan & Grunfeld, the firm that brought the class action lawsuit against the sheriff in 2018, said that mental health care in Santa Rita Jail has been essentially nonexistent for years. "There actually needs to be mental health care and treatment because there isn't any and there hasn't been for a long time," Bornstein said. "As long as we've got a jail we've got to make sure that it's actually able to take care of people in a constitutionally compliant way."

Alameda County Sheriff's Office Sgt. Ray Kelly, a department spokesperson, acknowledged that the settlement will require substantial changes to the jail's operations. "It's been a good process, a difficult process, but it's going to be of great benefit to the people in our custody," Kelly said about some of the new policies,

procedures, facilities, and programs that would be created under the proposed agreement.

The reforms "will take many years to finish," Kelly said. "Obviously the more efficiently we do that the better off for everybody because ultimately it is going to be costly to the taxpayers, and at the end of the day we want to make sure we're providing the treatment and care to the people who need it."

The agreement will place the county under court supervision, called a consent decree, for up to six years, and potentially longer if the sheriff's office is found out of compliance after that time. A similar agreement requiring reforms of the Oakland Police Department that was supposed to be completed in five years has gone on for nearly two decades. A similar lawsuit alleging that Sacramento County jails were mistreating prisoners with mental health issues and abusing the use of solitary confinement was settled in 2019, resulting in a consent decree requiring numerous reforms.

The sheriff's office must remake its intake and discharge procedures

Some of the biggest changes the sheriff's office will have to make, if the settlement is approved, involve how people are booked into the jail and what happens when they are released. The new procedures are designed to help place people in appropriate treatment and coordinate better with other county agencies.

While new inmates are medically screened at intake, they are not routinely screened for mental health issues. The DOJ report cited two cases where failures at intake led to the death of an inmate: Edwin Villalta, a former Marine suffering post-traumatic stress disorder, died by suicide in 2017, 18 days after entering the jail and after a doctor found he was not suicidal, and Christian Madrigal, who received no mental health screening despite his family calling police to have him hospitalized during a psychiatric emergency.

The jail will be required to screen anyone brought to it while the arresting officers are still there to determine if it would be more appropriate for them to be taken to a hospital under an involuntary mental health hold.

The settlement will also make mental health screenings routine at intake, and they must be completed within four hours. Anyone who is determined at that screening to have immediate suicidal behavior must be seen by a mental health professional within the next four hours. Anyone showing delusional behavior or who has been suicidal in the past 30 days must be seen in 24 hours. Anyone else who requests mental health treatment, or is referred by staff, must be seen within 14 days.

The jail will also be required to change the way it releases detainees. The DOJ investigation found that when people are released from jail they often are given few instructions for how to receive mental health services outside the jail and sometimes leave without any prescribed medication, increasing the chances that they will have a recurring mental health crisis and end up either in the hospital or back in jail.

Under the proposed settlement, once anyone receiving mental health treatment in the jail has been there for more than 72 hours, the staff must create a release plan and continue updating it as long as the person is in custody. Jail staff must coordinate with community service providers, housing providers and the detainee's friends and family, and if the person authorizes it, provide access to records to help create the release plan. Anyone taking psychiatric medications must have access to a 30-day supply of the medication when they are released.

The sheriff's office will build a new therapeutic housing unit

For many years, the jail used spartan "safety cells" to hold detainees in isolation who are suicidal, sometimes for weeks at a time. These cells contain no furniture and have only a hole in the floor for a toilet. The proposed settlement aims to significantly reduce the amount of time inmates spend by themselves in these cells.

The sheriff's office must restructure its categories for who needs to be housed securely and take a person's mental health condition into account when making those decisions. Even the inmates in the most restrictive tier will be entitled to two hours out of their cell per day. And if any behavioral health patients are placed in restrictive housing, they must be evaluated by a mental health professional within 24 hours.

The sheriff's office has agreed to phase out the use of "safety cells" and to reconfigure new suicide restraint cells in which detainees will be placed for no more than eight hours at a time. They must be re-assessed by a mental health professional and either taken to a different cell or hospitalized after that point.

The sheriff's office will also be required to create a new therapeutic housing unit where detainees with serious mental health problems would be looked after. While the sheriff's office currently has a behavioral health unit, the class action lawsuit alleged that often people with mental health issues were housed in "administrative segregation" cells, essentially solitary confinement, and that the behavioral health unit provided no meaningful care.

The DOJ found that care in the behavioral health unit was "generally limited to medication administration, screenings for suicidal ideation, and brief conversations with clinicians." The lead plaintiff in the class action case, Ashok Babu, who was arrested for domestic violence in 2017, was housed in the behavioral health unit on suicide watch, but the lawsuit alleges he was confined to his cell for 23 to 24 hours per day.

The new unit would provide more time outside, give people access to educational and mental health programs, and coordinate better with other county mental health providers.

"It's supposed to be more therapeutic and treatment-oriented instead of more punitive," said Bornstein, the attorney in the class action case. "We're cautiously optimistic that by working together with them by implementing this unit we'll be able to come up with ways that are genuinely helpful to people compared to what they've been in the past."

The sheriff's office must have a plan for the new units within three months and be using them within a year.

Jail staff will also be required to conduct mental health care in confidential settings. The DOJ found that many detainees had to talk with mental health care providers in places where other inmates and deputies were present and could overhear. The lack of privacy made detainees reluctant to share sensitive information.

Other new policies adopted by the sheriff's office will include an updated use of force policy and new rules for when and how restraints can be placed on detainees. Already the sheriff's office has ended the use of Wrap full-body restraints, which led to the death of Dujuan Armstrong while he was suffering an apparent mental health crisis in 2018.

New oversight positions will be created to ensure compliance

Bornstein said his team wanted to "find a way to have people affected by policies and procedures" to have a role in changing the conditions in the jail "in the hopes that we can make things better by working together instead of imposing it without talking to folks."

Along these lines, the jail will set up an inmate advisory council and ombudsperson, who will address grievances from inmates about conditions in the jail. The council will strive to have representatives from all housing units and jail classifications.

The jail also must add a new coordinator to ensure compliance with the Americans with Disabilities Act, a landmark civil rights law passed in 1990 that prohibits discrimination based on disability. The DOJ found that Alameda County's treatment of people with chronic mental health conditions violated the ADA because they were not provided legally required services in the community and instead were jailed, where their rights were violated further.

The ADA coordinator must meet with anyone admitted to the jail with a psychiatric disability within 14 days to explain the rules of the jail, how to request accommodations for their disability, what accommodations are available, and how to raise a grievance for an issue related to their disability. If they remain in jail for more than 60 days, the ADA coordinator must meet with them again to ensure that their needs are being addressed.

The sheriff's office is prohibited from considering a psychiatric disability as a factor when determining what restrictions to place on the detainee's movement. While they can consider whether a detainee's condition is causing them to be victimized, deputies can't place more restrictions on them just because they have a psychiatric condition.

Staffing in the jail will increase

One of the reasons conditions in Santa Rita Jail have been so bad is that there isn't enough staff to look after and serve the roughly 2,000 detainees. The county has agreed, according to the proposed settlement, to boost staffing of both the sheriff's office and mental health workers.

"You need to have the right staffing mix so that you can provide them with not only the constitutionally-mandated out of cell time that they're entitled to but especially with regard to mental health treatment," Bornstein said. "We would love to see Alameda County use other alternatives such as not putting people in jail and finding community-based programs and we are hoping that is something they will consider."

Mike Brady of Sabot Consulting, a former assistant secretary of the California Department of Corrections and Rehabilitation who is an expert on jails and prisons, recommended in an April 2020 report that Alameda County hire 259 additional deputies and 72 sheriff's technicians over a three-year period so the jail can operate without mandatory overtime.

Based in large part on Brady's report, the Board of Supervisors voted in May 2020 to allocate $318 million over three years to increase staffing in the jail. That also includes funding to hire 107 behavioral health employees.

The agreement doesn't settle all the county's issues with mental health care

While the proposed settlement outlines extensive reforms, implementing them will take years and the county's problems with mental health care are far from resolved, even if the jail comes into full compliance. The DOJ found civil rights violations in all of Alameda County's mental health services, including conditions in the public mental health hospital John George Psychiatric Pavilion in San Leandro and the lack of community-based services for treatment.

A separate class action lawsuit brought by Disability Rights California is still pending in federal court alleging inadequate community-based services and harsh conditions in John George hospital.

Finally, if the county does not reach a settlement with the DOJ based on what its civil rights division investigators found, it could be sued by the federal government as well.

Fixing mental health care will also be costly. As part of the settlement, Alameda County has agreed to pay the attorneys who filed the jail mental health lawsuit $2.15 million.

But Kelly, the sheriff's spokesman, said that he expects the changes to be transformative.

"It's going to ultimately change the way our organization's run, the way the county jail is run," Kelly said. "When you look back over the history of law enforcement in the county jail this will be a pivotal moment."

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Monday, August 30, 2021 8:41 AM
To: Works-Wright, Jamie
Subject: FW: August Liberated Minds Mental Health Equity Newsletter

Please see the information below from Margaret Fine

Jamie Works-Wright
Consumer Liaison
Jworks-wright@cityofberkeley.info
510-423-8365 cl
510-981-7721 office

From: Margaret Fine <margaretcarolfine@gmail.com>
Sent: Friday, August 27, 2021 6:31 PM
To: Works-Wright, Jamie <JWorks-Wright@cityofberkeley.info>
Subject: August Liberated Minds Mental Health Equity Newsletter

Hi Jamie,

I hope you're well.

I am passing along the monthly newsletter from the California Pan-Ethnic Health Network. This organization brings together and mobilizes communities of color to advocate for public policies that advance health equity and improve health outcomes. This newsletter focuses on mental health, including events.

Would you kindly forward it to the Mental Health Commissioners? Thank you so much! Best wishes, Margaret (Fine)

August Liberated Minds Mental Health Newsletter!

We are a network of diverse communities that want to achieve mental health equity

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In this Issue:

Covid 19 Impact on Mental Health

FORBES MAGAZINE: The Delta Variant Is Creating A Second Wave of Mental Health Issues: Here's How to Fight Back

With the Delta Variant rising, mental health is continued to be impacted. "New mandates have been ordered, such as showing proof of vaccination to get into restaurants, bars and gyms in New York and San Francisco". *The Washington Post* refers to the moods swiftly shifting to fear and seriousness as the "pandemic flux syndrome".

Many people have started to feel exhausted & unstable. "Each day seems to get increasingly harder. There's unrelenting stress without any light at the end of the tunnel...Prolonged unrelenting stress, aggravation, and anxiety leads us to emotional, mental and physical exhaustion."

Forbes Magazine states, "Share your feelings with your loved ones, so they know what you are going through... Try to go outdoors and get some sunlight... Collaborate on a plan to improve your work-life."

Click here to read more.

Upcoming Events

The Right to Heal: Centering Mental Health Multi-Racial Equity in California

The California Pan-Ethnic Health Network and statewide partners Southeast Asia Resource Action Center, California Black Health Network, Latino Coalition for a Healthy California, and California Consortium for Urban Indian Health invite you to register for our '**Right to Heal: Centering Mental Health in Multi-Racial Equity in California**' statewide virtual event.

The Right to Heal will be an opportunity for our partners to:

· Share their local mental health findings with policymakers and stakeholders

· Break down systemic barriers in mental health by centering BIPOC needs

· Build and strengthen community

· Inspire community members to take action and stay engaged in mental health advocacy

Event Details:

Date: September 22, 2021

Time: 10am to 3pm Pacific Time

Location: Virtual

Cost: Free!

Please click here to register.

Right to Heal Zine Submissions

In conjunction with our Right to Heal event happening on Wednesday, Sept 22nd, we are hosting a Zine Contest! We welcome your creative submissions, in honor of our event theme, portraying what “the right to heal” means to YOU!

The deadline to submit is 9/4 at midnight

Please click here to register.

Mental Health Matters Day 2021

About the Mental Health Matters Day 2021: It is being organized and hosted by Mental Health America of California (MHAC) on Wednesday, September 29, 2021! Filling out the save the date will also sign you up to receive updates about this year's program leading up to the event.

This year's theme is "*Resilient California: Celebrating Diversity and Connecting for Wellness*."

Please click here to register.

RSVP for Sisters Mentally Mobilized OAKLAND/BAY AREA Info Session

Sisters Mentally Mobilized is that space, a movement for Black women to tend to their mind care, heart care and soul care.

Sisters Mentally Mobilized is a Black women-centered mental health initiative that blends community advocacy training and the formation of Sister Circles in communities where Black women live, work, play and pray. They have offered this program in the Inland Empire, Sacramento, Los Angeles, and Oakland/Bay Area.

About the California Black Women's Health Project

The California Black Women's Health Project (CABWHP) is the only statewide, non-profit organization that is solely committed to improving the health of California's Black women and girls through advocacy, education, outreach and policy. We are committed to advocating for policies and practices that promote and improve the physical, spiritual, mental and emotional well-being of Black women and girls in California.

Please click here to register.

Legislative Updates

Thank you to all the Liberated Minds subscribed who signed on to support the inclusion of tribal healers for substance use disorder treatment services in Medi-Cal! The final letter can be found here.

Background:

The California Department of Health Care Services (DHCS) recently submitted a proposal to the federal Centers for Medicare and Medicaid Services (CMS) that, among many other policy proposals, requests federal approval to include tribal healers in the state's substance use disorder treatment services. Tribal healers and natural helpers have a strong record of providing culturally appropriate and effective services in Native American communities, and are often preferred to "medical model" services. Yet, their value is not currently recognized by the Medi-Cal program and they are not included and reimbursed.

Thanks to the fierce advocacy of Native American communities and leaders, including the California Consortium for Urban Indian Health, DHCS acknowledged the value of these healers and include them in the policy submission. Now CMS must decide whether to approve or deny the proposal. The advocacy letter calls upon CMS to approve the proposal and utilize California's experience as a model for other states.

News & Resources

BLOG POST: 11 Soothing Pre-Sleep Habits for a Restful Night and Productive Next Morning

"It's all about calming down your brain and your body."

Amy Marturana states, "It's time to talk about pre-sleep habits that might help. Busy schedules and

busy brains cut into precious sleep time...". Some pre-sleep habits as recommended by SELF

1. Give Meditation a try
2. Write down to-dos and other thoughts that might keep you up at night
3. Listen to a bedtime stories for adults

Click here to read more.

Culturally Competent Providers & In Language Resources

Therapists of Color Bay Area

Click here to find more information.

Books & Podcasts Centering BIPOC

Therapy for Black Girls

The Therapy for Black Girls Podcast is a weekly chat about all the things mental health, and personal development.

Click here to listen and here to find a therapist .

Healing Out Lao'd

Healing Out Lao'd is a virtual practice space exploring the intersections of Lao diaspora storytelling x healing x tools for sustainability!

Click here to listen

MHSOAC Meetings

In partnership with both the California Alliance of Child and Family Services and The Children's Partnership, the Commission will co-host a virtual panel conversation on Prevention and Early Intervention (PEI) and school and community partnerships. A panel of community providers who serve California's children and youth will highlight opportunities to promote mental health and wellbeing among youth, especially those currently and historically marginalized. Attendees will hear PEI strategies for children and youth and discover effective practices in communities.

The panel will take place online on **September 1, 2021 from 4:30 to 6:00 p.m**.

Click here to register for the event.

The Mental Health Services Oversight and Accountability Commission (MHSOAC) works through partnerships to catalyze transformational changes across service systems so that everyone who needs mental health care has access to and receives effective and culturally competent care. The role of MHSOAC is to oversee the implementation of the Mental Health Services Act (MHSA). They are responsible for developing strategies to overcome stigma.

Save the Date for the September MHSOAC Commission Meeting Teleconference happening on

September 23rd 9am-1pm.

Click here to register for the event.

Forward

Twitter

Website

LinkedIn

Our mailing address is:
California Pan-Ethnic Health Network (CPEHN)
1221 Preservation Park Way Ste 200
Oakland, CA 94612-1279

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Wednesday, August 25, 2021 12:03 PM
To: Andrea Prichett; boona cheema; Edward Opton (eopton1@gmail.com); Javonna Blanton; Margaret Fine; Maria Moore; Monica Jones; Taplin, Terry
Cc: Works-Wright, Jamie
Subject: Agenda Items for MHC September 23 meeting

Hello Commissioners,

I hope you all had a good break from our August meeting. As I prepare for the September meeting, please send me your agenda items by Friday, September 3rd and any items to put in the packet by Friday, September 10th.
Thank you for your time.

Jamie Works-Wright
Consumer Liaison
Jworks-wright@cityofberkeley.info
510-423-8365 cl
510-981-7721 office

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Wednesday, August 25, 2021 8:18 AM
To: Works-Wright, Jamie
Cc: Grolnic-McClurg, Steven; Klatt, Karen
Subject: FW: MHSA INN Homeless Encampment Wellness Project - contract, MHSA docs, studies, notes
Attachments: Homeless Encamp MHSA INN Community Planning Report.pdf; Homeless Encampment Draft MHSA INN Project Plan June 2021.docx; Homeless Encamp Contract RDA_MHSA INN Planning Services.pdf; Homeless Encamp Research 1st Hand Accts Ppl SMI SUD.pdf

Please see information below from Margaret Fine

Jamie Works-Wright
Consumer Liaison
Jworks-wright@cityofberkeley.info
510-423-8365 cl
510-981-7721 office

From: Margaret Fine <margaretcarolfine@gmail.com>
Sent: Tuesday, August 24, 2021 10:12 PM
To: Works-Wright, Jamie <JWorks-Wright@cityofberkeley.info>
Subject: MHSA INN Homeless Encampment Wellness Project - contract, MHSA docs, studies, notes

Hi Jamie,

I hope you are well. I would sincerely appreciate it if you would kindly forward this email and the attachments to the Mental Health Commissioners, the Mental Health Division Manager and the MHSA Coordinator, Karen Klatt. The attached materials are also gathered for the Agenda Packet for September—although we may need to ensure the latest proposal draft is included.

Dear Commissioners,

The proposed MHSA INN Homeless Encampment Wellness Project will be listed on the Agenda for the Mental Health Commission Meeting on Thursday, September 23, 2021 at 7 pm. There will also be a public hearing on this project in the not too distant future (maybe December 2021 or January 2022).

I have gathered the primary documents related to the Homeless Encampment Wellness Project so we are prepared for our upcoming September meeting and thereafter. The MHSA Coordinator, and potentially RDA, will attend and answer questions. The attached documents are relevant and important to consider:

1. City of Berkeley contract with Research Development Associates (RDA) for Stakeholder Engagement and MHSA INN Proposal Writing

2. RDA Stakeholder Report (see notes below re: extensive community input)

3. Draft Berkeley Innovation Project Plan for an Encampment-based Mobile Wellness Center to be operated by the Division of Mental Health, dated 6/21

4. First-hand studies reflecting perspectives of people with serious mental illness and their experiences with homelessness

In addition as promised, I made notes from the discussion about this proposed project during the last MHSA Advisory Committee meeting on Tuesday, August 17, 2021 from 11 am - 12:30 pm. The notes are as follows:

The MHSA Coordinator, Karen Klatt, opened the meeting by discussing the history of the MHSA Homeless Encampment Wellness project.

Karen explained the MHSA CPP (Community Planning Process) and how state law mandates a community input process for developing a specific mental health program under the Mental Health Services Act (MHSA). This process for the MHSA INN Homelesss Encampment Wellness Project started before COVID, there was a pause and then it resumed in fall 2020.

This Community Input Process has been extensive, including an online community survey with 102 people; a virtual Townhall with 30 people; connections with 32 homeless people with lived experience of homelessness; 2 meetings with stakeholders including 18 CBOs and 20 individuals; 40 staff responses. The MHSA INN Stakeholder Report on this process is attached for your review. The project must be rooted in this feedback.

In addition MHSA INN projects must meet other requirements focused on innovation (such as developing new best practices for outreach and engagement with unhoused people) in order to be eligible for this type of MHSA funding. For instance, some of the innovations for this Project may include trauma-informed best practices for providing food, hygiene, and access/delivery services; and being fully staffed by peer-led teams from the encampments and CBOs that serve them. Some people who are experiencing homelessness are not engaged and/or not interested in service/treatment arrangements. They are so traumatized and skeptical that there is a need for an organic process, including as done during the CPP process to reach people with lived experience of homelessness or experiencing homelessness, CBOs serving them, staff and more (see above). This MHSA INN Project is also coordinated with other City of Berkeley senior staff and the Division of Mental Health receives their feedback.

The Project would be overall designed as a self-sustainability and wellness path among the peer support network in the community—it's about building community for increased wellness by people who are peers with lived experience of mental health and substance use challenges. There would need to be a phased implementation process in order to build trust and rapport, and set up a collaboration among peers and community-based organizations. It would start small and build. Peers would also need to know their own capacity; have support for their wellness built into the job; not have too many big tasks; and meet people where they are at. Peers would be a resource, helping people with tools, possibly as a bridge. It is important not to overextend people. There will be trainings as well.

There is a need to build community among unhoused people. There may be an interest in linkages and services. Currently there are multiple outreach teams, including community-based organizations. Some people are not connected

to treatment. Similar elements as Wellness Centers. There would outreach for peer staff from their own communities and in places such as shelters. It's an advantage for the whole staff to be organizing, advocating, doing projects such as in community gardens, having people working together and feeing pride, developing camaraderie.

Overall this information should provide Commissioners with the opportunity to ask meaningful questions about this project, and I look forward to our discussing it.

Best wishes,
Margaret

Margaret Fine
Chair, Mental Health Commission
Cell: 510-919-4309

EXPENDITURE NON-CONSTRUCTION CONTRACT REVIEW FORM: AMENDMENT

Contract # 32000129 VENDOR # 19227

CONTRACTOR NAME: Resource Development Associates (RDA)

Subject of Contract: MHSA Innovations (INN) Planning and Technology Suite Project Coordination Services

This contract package contains: 3 Original Contracts (Department, Vital Record and Vendor) in folders *The Vital Record contract MUST be in a folder. *Optional: In lieu of folders, Department and Vendor copies may be assembled with an Acco-fastener.	With Original Contract	Attached	Waiver Attached	Not Required
1. Scope of Services and Term	☐	☒	☐	☐
2. Payment Provisions	☐	☒	☐	☐
3. Sanctuary City Compliance Statement	☒	☐	☐	☐
4. Living Wage Certification (*if not submitted with original contract*) ***LWO use current form on web****	☒	☐	☐	☐
5. Certification of Compliance with Equal Benefits Ordinance (if not submitted with original contract) ***EBO use current form on web****	☒	☐	☐	☐
6. Federally Funded Project Requirement **ONLY**: Debarment status printout ($25,000 and above) SAM.gov		☐		☒
7. Insurance Certificate/s AND Endorsement/s OR Insurance Waiver/s *(originals, not copies)*		☒	☐	☐
8. Authorizing Council Resolution # 69,703-N.S. January 26, 2021		☒		☐

Berkeley Business License # BL-003113

Requisition # _____ (Hard copy attached) **Purchase Order #** _____

Budget Code: 315-51-503-526-2017-000-451-612990= $10,000 and 315-51-503-526-2020-000-451-612990=$39,000. **Council Approved Amount $** 97,850.

Was there any advance payment? No ☒ Yes ☐ ..... **If Yes, Advanced Amount $** _____

If Yes, Purchase Order # _____

Original contract amount	$ 48,850
Amount/s added by previous amendment/s (if applicable)	$ _____
Amount added by this amendment	$ 49,000
Total/cumulative contract amount after amendment	$ 97,850
Contingency	$ _____
TOTAL NOT TO EXCEED AMOUNT	**$ 97,850.**

Routing and signatures:

All elements of the contract package, including information provided above and on Amendment Data Transmittal form (page 2), have been reviewed for completeness and accuracy and evidenced by the following signatures (Project Manager please print name):

Andrea Bates	Andrea Bates	HHCS-Mental Health-MHSA	(510) 981-7647	03/17/2021
1. **Project Manager (PRINT NAME)**		**Department**	**Phone No.**	**Date**
Ann Song	Ann Song		4/22/2021	
2. **Department Administrative Officer / Accounting**			**Date**	
Lisa Warhuus	A M. DL		4/22/2021	
3. **Department Head**			**Date**	
Josh Roben Darryl Sweet			4/29/2021	
4. **Contract Administrator**			**Date**	
Rama Murty Teresa Berkeley-Simmons	BUDGET APPROVED VIA EMAIL		4/30/2021	
5. **Budget Manager**			**Date**	

EXECUTED MAY 10 2021

Routing continues to the following persons, *who sign directly on the contract:*

6. **City Manager** *(Will not sign unless all signatures and dates appear above)*
7. **City Clerk:** CMS Login Destruct Review

* For current vendor forms, go to City of Berkeley website: http://www.cityofberkeley.info/ContentDisplay.aspx?id=5418 Rev 7/2020

City of Berkeley Contract Amendment Data Transmittal

(To be completed by Project Manager)

Resource Development Associates (RDA)
Contractor

2333 Harrison Street
Address

Oakland, CA 94612
City/State/Zip

Amended Contract Number:
32000129A

Contract Amendment Authority

☒ Resolution # 69,703-N.S. Original Resolution # 69,033-N.S.

☐ Ordinance # _____ (if appropriate)

☐ City Manager Authorization _____

Description of Amendment/s

☒ Change of Services/Scope: See Exhibit A and B

☒ Change of Dollars: Original Amount: $48,850 Amended Not to Exceed Amount: $97,850

☒ Change of Contract Term

Change as of This Amendment or Extension:

From: 02/01/2021 To: 01/31/2022

Change as of Prior Amendment (if any):

From: _____ To: _____

Original Term: From: 01/01/2020 To: 01/31/2021

Evidence of Insurance for Contract Amendment

Insurance	Waiver	Amount	Expiration Date	*TICKLER DATE* (City Clerk)
Professional Liability	☐	$2,000,000	10/01/2021	
General Liability	☐	$2,000,000	10/01/2021	
Automobile	☐	$2,000,000	10/01/2021	
Workers Comp.	☐	$2,000,000	07/01/2021	
Bond	☐	$		

Roben, Josh

From: Murty, Rama
Sent: Thursday, April 29, 2021 9:05 PM
To: Roben, Josh
Cc: Rosete, Michelle; Cole, Shamika S.; Dupaya, Maricar C.
Subject: RE: RESOURCE DEVELOPMENT ASSOCIATES - Contract Amendment

Budget Final - Approved

Rama Murty, Acting Budget Manager
City Manager's Office - Budget Office
Phone: 981-7044
Fax: 981-7099

From: Dupaya, Maricar C.
Sent: Thursday, April 29, 2021 3:36 PM
To: Murty, Rama <RMurty@cityofberkeley.info>
Cc: Rosete, Michelle <mrosete@cityofberkeley.info>; Cole, Shamika S. <SSCole@cityofberkeley.info>
Subject: RESOURCE DEVELOPMENT ASSOCIATES - Contract Amendment

Budget Initial – APPROVED

Notes:
Authorizing Resolution – 69,703-N.S.
New NTE due to amendment - $97,850
Contract # 32000129 change order entered in ERMA on 4/29/2021
New Contract Expiration – 1/31/2022

Funding in the amount of $10,000 is available in FY 2021 budget 315-51-503-526-2017-000-451-612990- and $39,000 in budget 315-51-503-526-2020-000-451-612990-.

Maricar Dupaya, Senior Management Analyst
Office of Budget and Fiscal Management
City of Berkeley, City Manager's Office
510-981-7046
mdupaya@cityofberkeley.info

Contract #32000129

AMENDMENT TO CONTRACT

THIS CONTRACT is entered into on February 1, 2021 between the CITY OF BERKELEY ("City"), a Charter City organized and existing under the laws of the State of California, and Resource Development Associates (RDA) ("Contractor"), a California corporation, doing business at 2333 Harrison Street, Oakland, California 94612.

WHEREAS, City and Contractor previously entered into Contract Number 32000129, dated January 1, 2020, to conduct Mental Health Services Act (MHSA) Innovations (INN) "Help@Hand" Technology Suite planning and project coordination, which contract was authorized by Berkeley City Council by Resolution No. 69,033-N.S.; and

WHEREAS, on January 26, 2021 by Resolution No. 69,703-N.S., the Berkeley City Council authorized amendment A of said Contract as set forth below.

THEREFORE, City and Contractor mutually agree to amend said Contract as follows:

1. Section 2 is amended to read as follows:

PAYMENT

For services referred to in Section 1, City will pay Contractor a total amount not to exceed $97,850. City shall make payments to Contractor in accordance with provisions described in Exhibit B, which is attached to and made part of this Contract.

2. Section 3.a. is amended to read as follows:

TERM

This Contract shall begin on February 1, 2021 and end on January 31, 2022. The City Manager of the City may extend the term of this Contract by giving written notice.

3. Further, this Contract is amended to include the following language regarding the City's Sanctuary Contracting Ordinance:

SANCTUARY CITY CONTRACTING

Contractor hereby agrees to comply with the provisions of the Sanctuary City Contracting Ordinance, B.M.C. Chapter 13.105. In accordance with this Chapter, Contractor agrees not to provide the U.S. Immigration and Customs Enforcement Division of the United States Department of Homeland Security with any Data Broker or Extreme Vetting Services as defined herein:

a. "Data Broker" means either of the following:

   i. The collection of information, including personal information about consumers, from a wide variety of sources for the purposes of reselling such information to their customers, which include both private-sector business and government agencies;

   ii. The aggregation of data that was collected for another purpose from that for which it is ultimately used.

b. "Extreme Vetting" means data mining, threat modeling, predictive risk analysis, or other similar services. Extreme Vetting does not include:

   i. The City's computer-network health and performance tools;

   ii. Cybersecurity capabilities, technologies and systems used by the City of Berkeley Department of Information Technology to predict, monitor for, prevent, and protect technology infrastructure and systems owned and operated by the City of Berkeley from potential cybersecurity events and cyber-forensic based investigations and prosecutions of illegal computer based activity.

In all other respects, the Contract dated January 1, 2020, shall remain in full force and

effect.

IN WITNESS WHEREOF, City and Contractor have executed this Contract as of the date written in the first paragraph of this Contract.

CITY OF BERKELEY

By _____
City Manager

THIS CONTRACT HAS BEEN APPROVED AS TO FORM BY THE CITY ATTORNEY FOR THE CITY OF BERKELEY
10/2019

Registered on behalf of the City Auditor by:

_____
Finance Department

Attest:

_____
Deputy City Clerk

CONTRACTOR

Patricia Marrone Bennett
Name (Printed)

By _____ CEO
Signature and Title

EXHIBIT A

SCOPE OF SERVICES

Resource Development Associates, (hereafter RDA) will provide the following services, enumerated below, necessary to the Community Program Planning and plan approval for the next round of Mental Health Services Act (MHSA) Innovations (INN) funds; and the Project Coordination for the MHSA Innovations Technology Suite Project. This contract is for the period commencing February 1, 2021 to January 31, 2022 which may be extended by agreement of the City of Berkeley and RDA.

MHSA Innovations Planning

RDA will facilitate the State required MHSA Community Program Planning (CPP) process to identify and prioritize needs and strategies to be implemented through the next round of MHSA INN funds. Duties include, completing the stakeholder input process to garner input from the community on local needs and suggested strategies; prioritizing strategies; collaborating with City MHSA staff and the Mental Health Oversight and Accountability Commission (MHSOAC) on the development of a draft plan; writing a draft plan; ensuring all steps have been executed to obtain an approved INN Plan through City Council and the MHSOAC.

Tasks will include:

1.) Community Program Planning: RDA will continue gathering input from internal staff, key stakeholders, and community members to inform a robust INN planning process rooted in community needs and ideas.

Task 1.1 Compliance and Feasibility Review: RDA will take all ideas suggested in the community kickoff meeting and through the submission process, document them, and screen out those that will not meet INN requirements. RDA will then meet with the City to discuss the ideas that have been submitted and which seem feasible for the City to pursue. All feasible ideas will go to the community planning session for further refinement and prioritization.

Task 1.2 Community Planning Sessions: Continuing work from the initial contract once a list of feasible ideas has been determined, RDA will facilitate two planning sessions. The first session will provide a brief overview of the process, including ways to provide input, and will spend most of the time engaging stakeholders in potential INN program ideas. The Community Planning Session will enable community members and other key stakeholders to have the opportunity to work together to co-create program design and implementation plans. For this meeting, RDA will provide any information needed to inform a productive discussion; facilitate a series of activities to further develop and potentially combine program ideas; and then conduct a prioritization exercise. To ensure that the discussion stays focused, RDA will create a "parking lot" list of issues that arise during the community planning session that are not germane to the primary task at hand. This will ensure that participants feel heard and understand that their issues will be addressed at a more appropriate time without distracting the group from their objective.

A separate session will be conducted that will include stakeholder groups with specific experience and expertise to help design proposals around topic areas.

Task 1.3 Report on Community Planning Process: RDA will provide the City with a report that will include: a description of the complete CPP process, including demographics of individuals who participated in the process; input received around needs and strategies; strategy prioritization process; and descriptions of the proposed prioritized strategies; descriptions of proposed project ideas.

Task 1.4 City Planning Session: Following the community planning session and report submission, RDA will meet with key City staff to finalize the innovation concept. During this meeting RDA will obtain any additional information that will be needed to draft the INN plan.

2.) Plan Development and Approval: Phase II will allow RDA to draft the Innovation plan in accordance with MHSOAC reporting requirements and gather public feedback.

Task 2.1 Innovation Plan Draft: RDA will write the INN Plan. RDA will work with City and MHSOAC staff to ensure the plan accurately reflects the needs of the community, is feasible, and is likely to be approved by the MHSOAC.

Task 2.2 Oversight and Technical Assistance in Ensuring Plan Approval: RDA will work with the City throughout the submission process providing project management and technical assistance to ensure all steps are executed to obtain an approved INN Plan through City Council and the MHSOAC.

In accordance with MHSA regulations, the INN Plan will be posted publicly for 30 days. RDA will support City staff in reviewing public comment and working with the City to respond to comments and make any agreed upon plan refinements prior to submission with the MHSOAC. RDA will be on hand to support the City on any subsequent plan refinements needed to obtain State approval on the INN Plan. These steps may include RDA participating in INN Planning calls between the City and the State and integrating State feedback into the plan prior to final submission to the MHSOAC.

Ongoing: Project Management and Communication

RDA will provide ongoing project management to support the quality, consistency, and timeliness of the deliverables. Project management tasks will include maintaining the project work plan, allocating and maintaining project resources, and providing oversight of each major deliverable proposed in this scope of work.

Regular communication will allow the opportunity for problem solving and the planning necessary to produce the deliverables proposed in this scope of work. Communications will include, at a minimum, regularly scheduled phone meetings with the City and RDA Team. RDA will maintain a project overview document that maps out key dates, tasks, deliverables, and responsibilities for all aspects of the project partnership between RDA and the City.

During the course of the work, it is possible that some of the deliverables may be changed, eliminated or modified, as needed. RDA will work with the City on any unforeseen necessary changes.

Project Timeframe

Depending on when the INN Plan can get on the MHSOAC Calendar for approval, it is envisioned that these services will be completed sometime within the June - September 2021 timeframe.

Payment

RDA will submit invoices for completed work in a total amount not to exceed $10,000.

Help@Hand (formerly Technology Suite) Project Coordination

RDA will serve as the primary point of contact for the MHSA INN Help@Hand Project. RDA will collaborate with internal staff to conduct all the necessary duties to prepare and support the launch and implementation of the City of Berkeley Help@Hand Project including but not limited to: meeting with the City's Help@Hand team (internal team) to establish strategic direction and ongoing activities of the project, collaborating with other participating counties, participating on calls and meetings with the California Mental Health Services Authority (CalMHSA), and working with internal staff and CalMHSA on the local deployment of Mental Health Applications (Apps).

RDA will work in collaboration with the City, Community members and area stakeholders including the MHSA Advisory Committee (the advisory stakeholder group which is comprised of a diverse group of consumers, family members, community advocates, Mental Health Commissioners, and representatives from un-served, underserved and inappropriately served populations). RDA will work with internal and external stakeholders to expedite the Help@Hand Project implementation process.

Project Coordination: RDA will continue Help@Hand Project Coordination work. Some of the coordination work will be ongoing throughout the project, as such RDA will work in a flexible manner with the City to accomplish the following work outlined below.

1. Help@Hand Product Validation

RDA will conduct Project Coordination for the MHSA INN Help@Hand Project and will be a liaison between the City and CalMHSA and the Technology Suite vendors and will ensure that all communications and information are relayed to BMH.

1.1 Support Marketing of Apps: RDA may be requested to be involved in supporting the marketing of Apps. This may include, but not limited to supporting the City with creating the Berkeley Help@Hand Marketing and Outreach Plan in collaboration with CalMHSA; adjusting Help@Hand marketing materials to reflect local preferences; providing marketing outreach support to local City partners; and working with CalMHSA on budget allocations.

1.2 Support Group Planning and Recruitment: If the City chooses to convene Peer Focus Groups RDA may be requested to support the City with various tasks related to group planning, recruitment, group facilitation and data review.

1.3 Vendor Meetings and Statement of Work Negotiation and Development: Lead development of the City Implementation Plan; prepare language for vendor negotiation meetings, facilitate negotiation meetings, develop Help@Hand Scope of Work collaboration with Berkeley, CAlMHSA, and vendor(s).

1.4 Implementation and Organizational Change Management Plan: In collaboration with the City and CalMHSA, develop the Berkeley Help@Hand Implementation/Organizational Change Management (OCM) Plan.

2. Implementation

2.1 Implementation Schedule Management: Coordinate and schedule interagency and cross-partner meeting coordination and scheduling.

2.2 Community Data Collection and Input Monitoring: RDA may be requested to either communicate and collaborate with a Help@Hand Evaluator for data collection and monitoring input, or to directly facilitate data collection and community input processes, e.g. Help@Hand participant surveys and survey data analysis, to inform project implementation processes and continuous quality improvement.

2.3 Implementation Oversight and Risk Mitigation: Collaborate with CalMHSA and the City to monitor risk, and take appropriate action as needed.

2.4 Ongoing Vendor Management and Communication: Provide ongoing vendor management and communication.

3. Stabilization

3.1 Identify Lessons Learned: RDA will work in collaboration with the City and/or Help@Hand Evaluator to develop the Berkeley Help@Hand "Lessons Learned" memo, for distribution among CalMHSA Help@Hand collaborative partners.

3.2 Ongoing Implementation Plan: Revise Berkeley Help@Hand Implementation Plan as needed, in collaboration with the City and CalMHSA, to support ongoing project implementation or expansion, and/or to recommend Organizational Change Management (OCM) processes, if applicable.

3.3 Identify Expansion Opportunities: In collaboration with the City and CalMHSA, RDA may be requested to provide direction and support on project sustainability planning.

4. Ongoing Project Management and Communication

Task 4.1 Project Management and Point of Contact: RDA will provide ongoing project management, overseeing day-to-day tasks to ensure that all project components are executed on time. This collaborative approach will ensure that individuals with the greatest knowledge and skills are used to benefit the project, and that the project is guided and monitored for quality assurance. RDA will serve as the primary point of contact across stakeholders for the coordination and implementation of the BMH INN Technology Suite Project and will be available for all ad hoc communications and issues that arise.

4.2 Monthly Meetings: Facilitate regular meetings and email communications with the City's internal team. These meetings will serve as a platform for continuous planning and monitoring of project activities, keeping the team informed and addressing any concerns that may arise. It will also be an opportunity to prepare for any upcoming meetings RDA will be in with CalMHSA. RDA will continue to be available between updates for communications and to address concerns, but will utilize these project updates to lessen the need for adhoc discussions and prevent issues before they arise.

4.3 Ongoing Strategic Direction and Guidance: Establish a timeline and coordinate the necessary duties to support the launch and implementation of the project to guide the internal team to successfully deploy the Help@Hand Apps and manage ongoing project activities. By establishing the strategic direction and a shared vision for the Help@Hand Project, RDA will be able to help the City and participating vendors effectively adapt should any challenges or avenues for refinement surface. RDA will collaborate with CalMHSA, vendors and other participating counties to create a cohesive approach that follows City preferences around the CalMHSA Help@Hand Project implementation recommendations.

4.4 Meetings with CalMHSA and Vendors: Participate in CalMHSA and Vendor conference calls and meetings including, but not limited to Tech Lead and Project Implementation meetings. RDA will work with the internal team to prioritize involvement in these meetings, while ensuring there is clear coordination for communication, planning and implementation activities.

During the course of the work, it is possible that some of the work areas may be changed, eliminated or modified. Additionally, some work areas may be added to support the project. RDA will work with the City on any unforeseen necessary changes.

Project Timeframe

It is envisioned that these services will be completed by January 31, 2022.

Payment

RDA will provide invoices for professional services for MHSA INN Help@Hand Project Coordination services at a not-to-exceed amount of $39,000 for the contract period of 2/1/2021-1/31/2022. This amount is calculated using the following hourly rates, approximating an overall RDA team engagement of five hours per week. The hours proposed are estimated and will be adjusted as appropriate during the course of the project; baring significant changes to the scope of services, RDA will not exceed the total budget amount for the contract. RDA will bill for services monthly for actual hours worked.

Position	Hourly Rate
Project Director	$225
Program Associate	$150
Research Associate	$125

RDA and Berkeley Mental Health will work out task requests through the year. RDA will let Berkeley know if any requests will require a greater lift than the approximate 5 hrs/wk and will work with Berkeley to rearrange services/deliverables to accommodate.

EXHIBIT B

PAYMENT

The cost for professional services for Mental Health Services Act (MHSA) Innovations (INN) Planning services is $10,000. The cost for professional services for MHSA INN Technology Suite Help@Hand Project Coordination services is $39,000. The original contract was for an amount of $48,850. The new Not-to-Exceed (NTE) total contract amount is $97,850. The term of the contract is 2/01/2021 – 1/31/2022.

Resource Development Associates (RDA) will bill the City for each area of professional services outlined in the Exhibit A on a monthly basis until the assignment is completed.

Payments will be made by the Finance Department in arrears after receipt and acceptance of proper, fully itemized, and correct invoices by the Finance Department.

Submit Invoices to:

Karen Klatt, MHSA Coordinator
3282 Adeline Street
Berkeley, CA 94704

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 09/24/2020

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME: Stefanie Connolly
Brown & Brown Insurance Services of California, Inc 3697 Mt. Diablo Blvd, Ste 100 Lafayette CA 94549-3745	PHONE (A/C, No, Ext): (800) 733-3131 FAX (A/C, No): E-MAIL ADDRESS: sconnolly@bbnca com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Sentinel Insurance Company, Ltd	11000
INSURER B : Beazley Insurance Company, Inc.	37540
INSURER C :	
INSURER D	
INSURER E :	
INSURER F :	

INSURED
Resource Development Associate
2333 Harrison St
Oakland CA 94612

COVERAGES **CERTIFICATE NUMBER:** 20/21 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	[X] COMMERCIAL GENERAL LIABILITY [ ] CLAIMS-MADE [X] OCCUR GEN'L AGGREGATE LIMIT APPLIES PER. [X] POLICY [ ] PRO-JECT [ ] LOC [ ] OTHER	Y		57SBAID4214	10/01/2020	10/01/2021	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG $	$ 2,000,000 $ 1,000,000 $ 10,000 $ 2,000,000 $ 4,000,000 $ 4,000,000 $
A	AUTOMOBILE LIABILITY [ ] ANY AUTO [ ] OWNED AUTOS ONLY [ ] SCHEDULED AUTOS [X] HIRED AUTOS ONLY [X] NON-OWNED AUTOS ONLY			57SBAID4214	10/01/2020	10/01/2021	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident) $	$ 2,000,000 $ $ $ $
	[ ] UMBRELLA LIAB [ ] OCCUR [ ] EXCESS LIAB [ ] CLAIMS-MADE [ ] DED [ ] RETENTION $						EACH OCCURRENCE AGGREGATE $	$ $ $
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? [ ] N/A (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below						[ ] PER STATUTE [ ] OTH-ER E.L. EACH ACCIDENT E L DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	 $ $ $
B	Professional Liability & Cyber Liability			V13940200801	10/01/2020	10/01/2021	$3,000,000 per Occ $3,000,000 per Occ	$25,000 retention

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

The City of Berkeley, its officers, agents, employees, and volunteers are named as additional insured as respects to services rendered by the named insured as respects to the genreal liability, subject to the policy terms, conditions and exclusions and per attached form SS 41 70 06 11. Policy Cancellation Exception: 10 days for non-payment of premium.

CERTIFICATE HOLDER

City of Berkeley Mental Health Department
2640 Martin Luther King Way
Berkeley CA 94704

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 10/01/20

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Aon Risk Services, Inc of Florida 1001 Brickell Bay Drive, Suite #1100 Miami, FL 33131-4937	**CONTACT NAME:** Aon Risk Services, Inc of Florida **PHONE (A/C, No, Ext):** 800-743-8130 **FAX (A/C, No):** 800-522-7514 **EMAIL ADDRESS:** ADP COI.Center@Aon.com
	INSURER(S) AFFORDING COVERAGE — **NAIC #** **INSURER A :** American Home Assurance Co — 19380
INSURED ADP TotalSource DE IV, Inc. 10200 Sunset Drive Miami, FL 33173 L/C/F Resource Development Associates Inc. 2333 Harrison Street Oakland, CA 94612	**INSURER B :** **INSURER C :** **INSURER D :** **INSURER E :** **INSURER F :**

COVERAGES **CERTIFICATE NUMBER:** 3148200 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS. LIMITS SHOWN ARE AS REQUESTED.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER.						GENERAL AGGREGATE	$
	☐ POLICY ☐ PROJECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	☐ OTHER							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DEC ☐ RETENTION $							
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N / A		WC 027137755 CA	07/01/20	07/01/21	X PER STATUTE ☐ OTH-ER	
							E.L. EACH ACCIDENT	$ 2,000,000
							E.L. DISEASE - EA EMPLOYEE	$ 2,000,000
							E.L. DISEASE - POLICY LIMIT	$ 2,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
All worksite employees working for RESOURCE DEVELOPMENT ASSOCIATES INC , paid under ADP TOTALSOURCE, INC's payroll, are covered under the above stated policy.

CERTIFICATE HOLDER

City of Berkeley Mental Health Department
2640 Martin Luther King Way
Berkeley, CA 94704

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Aon Risk Services, Inc of Florida

POLICY NUMBER: 57 SBA ID4214

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

ADDITIONAL INSURED - OWNERS, LESSEES OR CONTRACTORS - SCHEDULED PERSON OR ORGANIZATION

This endorsement modifies insurance provided under the following:

BUSINESS LIABILITY COVERAGE FORM

SCHEDULE

Name Of Additional Insured Person(s) Or Organization(s):
The City of Berkeley, its Officers, Agents, Employees and Volunteers

Location(s) Of Covered Operations:
California

Information required to complete this Schedule, if not shown above, will be shown in the Declarations.

A. **Section C. – Who Is An Insured** is amended to include as an additional insured the person(s) or organization(s) shown in the Schedule, but only with respect to liability for "bodily injury", "property damage" or "personal and advertising injury" caused, in whole or in part, by:

1. Your acts or omissions; or
2. The acts or omissions of those acting on your behalf;

in the performance of your ongoing operations for the additional insured(s) at the location(s) designated above.

B. With respect to the insurance afforded to these additional insureds, the following additional exclusions apply:

This insurance does not apply to "bodily injury" or "property damage" occurring after:

1. All work, including materials, parts or equipment furnished in connection with such work, on the project (other than service, maintenance or repairs) to be performed by or on behalf of the additional insured(s) at the location of the covered operations has been completed; or
2. That portion of "your work" out of which the injury or damage arises has been put to its intended use by any person or organization other than another contractor or subcontractor engaged in performing operations for a principal as a part of the same project.

RESOLUTION NO. 69,703-N.S.

CONTRACT NO. 32000129 AMENDMENT: RESOURCE DEVELOPMENT ASSOCIATES

WHEREAS, the City's Department of Health, Housing & Community Services, Mental Health Division, currently receives Mental Health Services Act funds (MHSA) Innovations (INN) funds on an annual basis for short term pilot projects that will increase learning in the mental health field through strategies that will either improve the access, quality, or outcomes of services, and/or promote community collaborations; and

WHEREAS, in order to utilize MHSA INN funds, state legislated community program planning and a community informed, City Council approved plan outlining the use of funds is required; and

WHEREAS, since 2012 the City Council has approved MHSA INN Plans; and

WHEREAS, on June 26, 2018, by Resolution No. 63,493-N.S., the City Council approved the MHSA INN "Help@Hand" Technology Suite Project to implement mental health technology applications (Apps) in Berkeley; and

WHEREAS, in 2019, the Mental Health Division executed recruitments for proposals for an MHSA INN Program Planner to execute the state required community program planning process for the next round of MHSA INN funds and projects, and for a Project Coordinator for the MHSA INN "Help@Hand" Technology Suite project; and

WHEREAS, Resource Development Associates was the chosen vendor for both of these areas of work, and Contract No. 32000129 was executed in the amount of $48,850 with Resource Development Associates to conduct MHSA INN planning and project coordination; and

WHEREAS, funds are available in the FY21 budget in the MHSA Fund, in the following amounts and budget codes: $10,000 in 315-51-503-526-2017-000-451-612990, and $39,000 in 315-51-503-526-2020-000-451-612990.

NOW THEREFORE, BE IT RESOLVED by the Council of the City of Berkeley that the City Manager is hereby authorized to execute an amendment to Contract No. 32000129 with Resource Development Associates to provide MHSA INN planning and project coordination services, to increase the amount by $49,000 for a total contract amount not to exceed $97,850, and to extend the term to January 31, 2022. A record signature copy of said contract and any amendments to be on file in the Office of the City Clerk.

The foregoing Resolution was adopted by the Berkeley City Council on January 26, 2021 by the following vote:

Ayes: Bartlett, Droste, Hahn, Harrison, Kesarwani, Robinson, Taplin, Wengraf, and Arreguin.

Noes: None.

Absent: None.

Jesse Arreguin, Mayor

Attest:
Mark Numainville, City Clerk

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Wednesday, August 25, 2021 8:16 AM
To: Works-Wright, Jamie
Subject: FW: Alameda County Mental Health Advisory Board Public Notice - Children's Advisory Committee Meeting (August 27th)
Attachments: MHAB Children's Agenda 08-27-21.pdf; 2021 July MHAB (CAC) UNAPPROVED Minutes.pdf

FYI

Jamie Works-Wright
Consumer Liaison
Jworks-wright@cityofberkeley.info
510-423-8365 cl
510-981-7721 office

From: MHB Communications, ACBH <ACBH.MHBCommunications@acgov.org>
Sent: Tuesday, August 24, 2021 5:04 PM
Subject: Alameda County Mental Health Advisory Board Public Notice - Children's Advisory Committee Meeting (August 27th)

Good afternoon,

Please find attached the August meeting agenda and unapproved minutes from July for the **Children's Advisory Committee Meeting on August 27, 2021 from 12:15 pm – 1:45 pm.**

Thank you.

Alameda County Mental Health Advisory Board

Alameda County
Mental Health Advisory Board

Mental Health Advisory Board Agenda
Children's Advisory Committee

Friday, August 27, 2021 ◊ 12:15 PM – 1:45 PM
2000 Embarcadero Cove, Suite 400, Oakland, CA 94606
(space is limited due to physical distancing requirements)
Teleconference: 1-866-899-4679**, Access Code:** 427-116-893

Committee Members:	**L.D. Louis** *(Chair, District 4)*

Due to the circumstances regarding COVID-19, the meeting will be held via teleconferencing.

12:15 PM Call to Order ..... Chair **L.D. Louis**

12:15 PM **I. Roll Call/Introductions**

II. Approval of Minutes

III. ACBH CHILDREN'S SYSTEM OF CARE REPORT (Lisa Carlisle, Director, Children's System of Care, ACBH)

IV. Chair's Report

A. MHAB GENERAL MEETING UPDATE

12:35 PM **V. DISCUSSION: Review of Forensic, Diversion, Re-entry System of Care: Juvenile Justice Services Presentation from July 23, 2021**

1:35 PM **VI. Public Comment**

1:45 PM **VII. Adjournment**

MHAB Children's Advisory Committee (CAC) UNAPPROVED Minutes
July 23, 2021 ◊ 12:15pm – 1:45pm◊ Via GoTo Meeting Video Conferencing

Meeting called to order @ 12:18p. by **LD Louis Deputy District Attorney (Alameda County Mental Health Unit)**

Attendees:	MHAB Members:	✓	LD Louis, MHAB Chair, Deputy District Attorney (Alameda County Mental Health Unit), Vice Chair of Mental Health Advisory Board and Head of Mental Health Unit for the Alameda County District Attorney's Office District 4				
			Joe Rose, President CEO of NAMI Alameda County South **NAMI National Alliance on Mental Illness-ACS**		Jessie Slafter, **East Bay Children's Law Attorneys** and **Member of Mental Health Advisory Board**		Sarah Oddie, Policy Advisor **Supervisor Wilma Chan's Office**
		✓	Adriana Furuzawa, Director of **Early Psychosis Division, Felton Institute** (Family Services Agency of San Francisco)		Lara Maxey, Director of External Affairs at **La Familia**		Kristin Spitz, Executive Director **Boldly Me**
			Ricki Garcia, Parent Partner at **Fred Finch**		Allison Massey, Program Director, Mental Health Association of Alameda County		Teri Talauta **NAMI Alameda South Board of Directors**
			Jackie Siefel, Clinical Supervisor at **Victor Community Support Services**		Dr. Fried, Program Manager, Outpatient Behavioral Health at Fairmont Campus, **Alameda Health System**		Kurtis, **Member of the TAY community**
	BHCS Staff:	✓	Angelica Gums, HR Liaison, **ACBH Office of the Director, Recording Secretary**		Tanya McCullum, Program Specialist, **ACBH** Office of Family Empowerment		Juan Taizan, Forensic, Diversion, and Re-entry Services Director, **ACBH**
		✓	Asia Jenkins, **ACBH Office of the Director**	✓	Lisa Carlisle, Director of CYASOC, **ACBH**		

ITEM	DISCUSSION	DECISION / ACTION
I. Roll Call	LD Louis conducted roll call	
II. Approval of Minutes	June minutes were approved	
III. Chair's Report by LD A. MHAB General Meeting Update	**Chair L.D. Louis provided her Chair's Report.** She explained that the Board has been busy. At the last meeting, the Board amended its bylaws, which have not yet been ratified by the Board of Supervisors. They approved the annual report. There were some updates from Dr. Tribble surrounding incompetent to stand trial (IST) individuals being returned to the local level and how it impacts our system of care. The Governor is to sign legislation to form a statewide working group to develop protocol and procedures on how that might be implemented. There is also a push to return those on LPS Conservatorship that are placed at the state hospital to the local level. Lastly, there was discussion surrounding the budget and the existing lawsuit with ACBH.	144

IV. ACBH Children's System of Care Report (Lisa Carlisle, Director, Child and Young Adult System of Care, ACBH)	**Director Lisa Carlisle provided updates for the ACBH Child & Young Adult System of Care (CYASOC).** She explained that there haven't been significant changes. They are actively recruiting for a CYASOC Assistant Director position. That is ongoing until filled. There are applications and resumes they are reviewing and are in the process of scheduling interviews for either August or September. They are also recruiting an early childhood mental health coordinator. In terms of service delivery, all our services are still up and running through a hybrid model, which includes virtual and in-person gatherings.	
V. DISCUSSION: A. Presentation – Foster Youth Services (Lisa Carlisle, Director, Child and Young Adult System of Care, ACBH)	**Following her Director's report, Director Carlisle began her presentation on foster youth services in Alameda County. The presentation was entitled Child and Young Adult System of Care Continuum of Care Reform and Specialty Services Overview.** Continuum of Care Reform (COCR) is also known as AB 403 and provides statutory and policy framework to ensure services and supports are provided for children and youth, his or her family, and is tailored toward the goal of returning the child home whenever possible to a permanent family placement. Essentially, it is the partnership between child welfare, behavioral health, and probation (usually the placing agencies), to determine the appropriate supports. There are a set of guidelines that they work under to find the appropriate placement for youth that are system-involved, in either child welfare or probation, and that provide the appropriate and nurturing home for children and youth. There have been significant changes to COCR since 2017. There have been implementation of child and family team meetings (CFTs), where they bring together the child's natural supports and help guide placement and treatment recommendations. They have a partnership with SSA on CFT teams and placements. There is also the establishment of resource families which provide family like settings and help to streamline approvals for foster youth into therapeutic foster care. Resource families are different than traditional foster parents. Resource families are selected by the placing agency in child welfare and are trained by ACBH mental health providers. They also bill medical for their services for children under their care. There has also been a change with the level of treatment/services provided by our group homes, in that group homes have now shifted to short term residential therapeutic programs (STRTPS). The State licenses STRTPs and approves mental health program/services. Mental Health Plans (MPHS) are required to certify with Medi-Cal and contract with any STRTP used by Child Welfare or Probation partners. Carrie Ware, licensed Marriage and Family Therapist with ACBH, sits on the Interagency Placement Review Committee. IPRC is comprised of ACBH, Child Welfare, and Probation. The meetings are held on the second and fourth Fridays of the month. They are currently meeting virtually/by phone. STRTP approval is based on medical necessity, commonality of need, and least restrictive placement. If placement is denied (which is a rare case) they discuss alternative referrals and they send out NOABD (notice of adverse benefit determination). They give that to the placement agency and they would discuss alternative services and the reason why they were denying those services.	

Director Carlisle explained that they analyze placement options because they no longer have level of treatment stages.

Question: Do we have facilities that accommodate the highest acuity/risk category of youth anymore? Are we setting up these youth for failure in facilities that don't have the structures necessary to manage higher acuity/higher risk behavior? Do we have suitable placement?

ACBH looks to determine which facility can accommodate the youth. There are less CTF (Community Treatment Facilities) than before. Placement options outside of a detention centers have greatly diminished. There are STRTP programs that can handle high level kids, but it requires a variation in the level of services.

Chair Lewis expressed concerns about mixing the population of youth diagnosed with a mental illness who have committed a certain crime, such as murder, with a youth who committed a lesser offense.

There is legislation happening at the state level that if passed may shift our operations. That information is forthcoming.

Director Carlisle continued with her presentation to discuss the following topics:

- Therapeutic Foster Care (TFC)
- California Assembly Bill 1299 Presumptive Transfer, a policy that ensures all foster children, youth, and Non-Minor Dependents receive timely access to Specialty Mental Health Services regardless of their county or residence.
- ACBH Presumptive Transfer Count from June 2020 – June 2021 Chart- Youth that left Alameda County and went to other counties.
- AB 1299 Successful Strategies
- Challenges with Presumptive Transfers
- Who Does the Work of CCR? It currently lives under the CYASOC Director but will eventually transition over to the Assistant Director.
- Intensive Care Coordination (ICC)
- Intensive Home-Based Services (IHBS)
- Therapeutic Behavioral Services (TBS)
- TBS Target Population/Eligibility Criteria – Allocation for TBS is $5.7 million dollars. There is a high turnover of TBS direct staff.

Question: How does the system of care define success when placing young people into varying programs and placements that you described?

- Director Carlisle expressed that the youth and families share success.

	Question: Has behavioral health accessed and reported out the performance of these various programs? How many young people have been reunited with family? How many have stepped out of the program and remain recidivism free? - Currently, there are no reports tracking this information. It's hard to develop a baseline since the rates change every year. We do need to do that and have a parallel between youth from ACBH and Probation. **Question: Do any of the programs have timelines?** - Youth are expected to stay in the program up to six months although it can be extended up to a year. Placement under six months should not exceed 120 days; and kids between 6 and 12 is to exceed six months. The focus is on shorter term treatment. - Chair Lewis would like to partner with CYASOC through her position with the District Attorney's Office to brainstorm ways they can report out on how these programs are performing. They are very interested in whether the needs of these young people are being met and that they are moving particularly away from the criminal justice system. They don't want youth involved in the child welfare system and juvenile justice system becoming part of the adult correctional system. That is one data point that we should all keep an eye on, even if some of these folks need public help services. - Director Carlisle meets with our QA team monthly on developing different trainings for STP partners. - Director Carlisle to roll out STP provider meetings in the fall. Specialty mental health services are new for STRTPs and ACBH is looking at ways to better equip and support them to increase efficiency. **Question: Working out placements in Committee, is there an equity lens and implicit bias in terms of diagnosis. Is there anything baked into your process where the team is doing gut check surrounding some of the racial equity lens type issues that can come up, type of placement, what is suitable, validity of diagnosis, etc.** - ACBH tries to have those conversations. Those take place more at the Child and Family Team meeting levels. Our committee reviews the diagnosis and determines if it meets medical necessity. We can expand and have those conversations, but we don't always have them. - Chair Lewis explained that diagnosis can impact access to services, for instance whether a youth should be on a mental health track and acuity level than a criminal justice track. - Diagnosis and treatment conversations may need to happen more at the guidance clinic level with ACBH.	**Director Carlisle to send Chair Lewis the presentation**
Public Comment on Items not on Agenda	No public Comment	.
VI. Adjourn	Meeting Adjourned 1:45 pm	
Next Meeting	**Friday, August 27, 2021 at 12:15p via GoTo Meeting**	

Minutes submitted by Angelica Gums

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Friday, August 20, 2021 5:01 PM
To: Works-Wright, Jamie
Subject: FW: Alameda County Mental Health Advisory Board Public Notice - Adult Committee Meeting (August 24th)
Attachments: Adult Committee Agenda 8-24-21.pdf; Adult Committee Minutes 7.27.21 UNAPPROVED.pdf

Please the attachments

Jamie Works-Wright
Consumer Liaison
Jworks-wright@cityofberkeley.info
510-423-8365 cl
510-981-7721 office

From: MHB Communications, ACBH <ACBH.MHBCommunications@acgov.org>
Sent: Friday, August 20, 2021 4:45 PM
Subject: Alameda County Mental Health Advisory Board Public Notice - Adult Committee Meeting (August 24th)

Good afternoon,

Please find attached the agenda and unapproved July meeting minutes for the **Adult Committee Meeting on August 24, 2021 from 12:00 pm – 2:00 pm.**

Thank you.

Alameda County Mental Health Advisory Board

Alameda County
Mental Health Advisory Board

Mental Health Advisory Board Agenda
Adult Committee

Tuesday, August 24, 2021 ◊ 12:00 PM – 2:00 PM
2000 Embarcadero Cove, Oakland, Eden Room
Teleconference: 1-866-899-4679, Access Code: 522-175-645
GoToMeeting Link: https://global.gotomeeting.com/join/522175645

Committee Members:	Marsha McInnis *(Chair, District 1)*

12:00 PM Call to Order Chair ..... **Marsha McInnis**

12:05 PM **I. Roll Call**

12:10 PM **II. Approval of Minutes**

12:15 PM **III. Chair's Report**

12:20 PM **IV. Director's Report**

12:45 PM **V. Presentations From NAMI Affiliates in Alameda County**

Joe Rose
President, NAMI Alameda County South

Gwen Lewis
President, NAMI Tri-Valley

Peggy Rahman
President, NAMI Alameda County

Liz Rebensdorf
President, NAMI East Bay

1:45 PM **VI. Committee Comment**

1:50 PM **VII. Public Comment**

2:00 PM **VIII. Adjourn**

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

Adult Committee UNAPPROVED Minutes
July 27, 2021 ◊ 12:00 PM – 2:00 PM
2000 Embarcadero Cove, Oakland, CA
Eden Room
Video Conference Meeting

Alameda County
Mental Health Advisory Board

Committee Members:	☒ **Marsha McInnis** *(Chair, District 1)*
ACBH Staff:	☒ **Kate Jones** *(Adult and Older Adult System of Care Director)*; ☐ **Jennifer Mullane** *(Adult and Older Adult System of Care Director)*; ☒ **Angelica Gums** *(Administrative Liaison and Recording Secretary)*; ☒ **Asia Jenkins** *(Administrative Liaison)*

Meeting called to order @ 12:00 PM by **Chair Marsha McInnis**.

ITEM	DISCUSSION	DECISION/ACTION
Roll Call	Roll Call completed.	
Emergency Action	None.	
Approval of Minutes	April minutes tabled.	
Correspondence	None.	
Chair's Report	**A. Chair McInnis welcomed the Committee and introduced the topic of today's discussion regarding the CalAIM Initiative proposed by the Department of Health Care Services.** **B. Kate mentioned that next month will be her last month serving on the Board.**	
Director's Report	**C. Kate Jones from Alameda County Behavioral Health, Adult and Older Adult System of Care, provided the Director's report.** Kate thanked Marsha for her advocacy and passion in serving mental health clients. She explained that ACBH will continue to work on three main areas of focus over the next two years: • Better communication and collaboration with Substance use providers and peers and trying to, despite 42 CFR, try to communicate better between our systems and assist around individuals as they transition in and out of SUD treatment and to observe 42 CFR in the process. Kate met with SUD partners to discuss the decision to take people experiencing co-occurring	

ITEM	DISCUSSION	DECISION/ACTION
	disorders to Amber House. Individuals would be voluntarily admitted to Amber House or PES to be evaluated and referred to one of ACBH's crises residential facilities with the idea that we are treating that individual with their mental health crisis and not their SUD concern. • Another focus area is on Older Adults to see how we can provide opportunities for outreach and engagement. The Division wants to increase outreach to these individuals who are eligible for services but aren't receiving any. In addition, the Division is working on system-wide trainings to begin in 2022 on how to provide services to older adults. • Kate is restructuring her weekly care coordination meetings focused on inpatient facilities and individuals who present some sort of systems challenges in finding the right level of care. The restructuring will focus on the top 50 clients who are high need, high cost in either mental health or emergency departments, or forensic. Working with Alameda County Care connect to create reports for shared information exchange, also referred to as community health record. Identified individuals are considered "familiar faces." The goal is to work with individuals to decrease utilization of services in high cost/ high restrictive environments to ideally meet their wants and needs to have a better quality of life. They will begin these meetings in October. **Questions:** 1. **Has ACBH considered the timeframe in which it takes an individual to transition from various levels of care, i.e. from experiencing a psychotic state to becoming balanced?** Kate explained that they have critical care managers who can make decisions on a case by case basis on length of stay for clients. 2. **Is there anyway a family member of one of these 50 individuals can be involved in the weekly care coordination meetings devoted to them?** This is intended to be largely a provider meeting.	

ITEM	DISCUSSION	DECISION/ACTION
	3. Is there a way for a County to reward and incentivize itself for taking care of its familiar faces? I wish Alameda County can give itself credit and encouragement for saving lives especially considering how expensive this process can be. ACBH can reward itself with praise and we do have an incentive program with our Full-Service Partnerships in identifying key metrics with seeing individuals at key times, including how often and quickly etc. Hopefully we'll see a reduction in cost and types of services over time. **4. Is there ever a way the care coordination team committee can report to the MHAB or the BOS on what sorts of facilities or programs are in short supply for familiar faces?** Kate mentioned that she is unsure about this process at this time. **5. With COVID surging, what are the policies in the clinics that protect clients/staff?** There are now rotational schedules for staff and all staff are required to wear masks.	
Presentation on California Advancing & Innovating Medi-Cal (CalAIM) (Eric Yuan, Alameda County Behavioral Health, Office of the Medical Director Integrated Health Care Services)	**D. Chair McInnis introduced Eric Yuan as the presenter to discuss the new CalAIM initiative** CalAIM stands for **California Advancing and Innovating Medi-Cal**. It is a multi-year initiative proposed by DHCS to ultimately improve the health outcomes, quality of life and consumer experience for Medi-Cal beneficiaries. Eric presented on key areas of the initiative including, CalAIM's Goals and Initiatives, the Enhanced Care Management Framework and implementation dates, and In Lieu of Services. **Questions:** **1. Considering the timeline that we have; what kind of consumer involvement are we looking at? How are we going to feed in the consumer voice?**	

ITEM	DISCUSSION	DECISION/ACTION
	Consumers will be involved in the stakeholder planning meetings for CalAIM, which includes helping to create a recovery plan for the client, receiving consumer feedback, and development of a client satisfaction survey. ACBH is not quite ready to put forth a draft proposal yet. There may be a place for peers to do outreach to get people engaged with the program. There is also an emphasis on qualitative services. Eric addressed concerns around basic needs. A couple of years ago the Office of the Medical Director was heading care coordination policies and procedures to improve care coordination for client. This project turned into the mental health system program improvement project that is supported by our department. 2. **People think of Managed Care as a way for a provider to put up resistance to expensive measures that aren't necessary. Might Managed Care theoretically make it more difficult for the SMI to get acute or subacute care quickly? This is not something a client is likely to demand but it is something a client with SMI may need occasionally. Also, it costs $450-3000 a day to my knowledge** Kate started a workgroup that reviews the screening/transition of care process for clients to ensure they are funneled into the right level of services. DLA-20 is a tool to help the individual determine how they are doing. 3. **Will there be state directed rates for outpatient services for mild to moderate and will there be separate rates for EPSTD and other medical services for court clients?** Kate explained that she is not aware of information right now and that there is a workgroup that discusses payment transformation information to DHCS and they are examining many different methodologies for payment reform.	

ITEM	DISCUSSION	DECISION/ACTION
	4. Is the tool at this moment just self-reporting data or does it involve a clinical assessment? DLA-20 is an assessment of the daily functioning of the client. It is a clinical tool that the clinician/providers share with the client and can determine the result together. **5. If a person is in a state of psychosis, is it tracking their perception of how they are doing or is there a separate or additional place for clinician to comment on that thing?** Eric stated that we need a trained clinician to know when to use these tools, such as when the client is facing a psychotic break it may not be the appropriate time for the client to do a co-assessment. **Eric continued the presentation to highlight the ACBH Model of Enhanced Care Management, which included the following information:** • Why ACBH should participate in CalAIM to be enhanced care management providers; Member Experience; Quality of Care; Member Outcomes, • Piloting at ACBH Community Support Centers (CSC) – Outreach, Care Coordination Capacity, and Health Promotion • Four (4) Community Support Centers • ECM Model Workflow: Membership Assignment • ECM Model Workflow: Outreach and Engagement • ECM Model Workflow: Assessment and Plan Development • ECM Model Workflow: Service Provision • ECM Model Workflow: Re-assessment	
Committee Comment	Committee member Warren commented that he appreciates the dialogue and being able to learn from Marsha during these meetings.	
Public Comment	None	
Adjournment	Adjourned at 2:00 PM	

Minutes submitted by A. Gums

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Tuesday, August 17, 2021 8:43 AM
To: Works-Wright, Jamie
Cc: Grolnic-McClurg, Steven; Warhuus, Lisa
Subject: FW: Harm Reduction Virtual Conference, Keck School of Medicine, USC 9/25/21

Hello All,

Please see the email below with information about a conference. Message from Margaret below

Jamie Works-Wright
Consumer Liaison
Jworks-wright@cityofberkeley.info
510-423-8365 cl
510-981-7721 office

From: Margaret Fine <margaretcarolfine@gmail.com>
Sent: Monday, August 16, 2021 9:12 PM
To: Works-Wright, Jamie <JWorks-Wright@cityofberkeley.info>
Subject: Harm Reduction Virtual Conference, Keck School of Medicine, USC 9/25/21

Hi Jamie,

Would you kindly send this email to the Mental Health Commissioners?

I would also appreciate your sending this email to the Mental Health Division Manager and please ask him to share with the medical staff?

In addition I would appreciate it if you could send this notice to the Director of Health, Housing and Community Services.

Thank you so much!

Here is detailed conference information:

Harm Reduction Los Angeles and the Keck School of Medicine at University of Southern California (USC) are hosting an important conference on Harm Reduction in Clinical Praxis. The guest speaker is Dr. Kim Sue, who is the Medical Director for the National Harm Reduction Coalition, and her bio is below.

The AMA is awarding 5 hours of continuing medical education credits, and the conference fee is very very reasonable.

Conference Website:
https://keckusc.cloud-cme.com/course/courseoverview?P=4&eid=2896

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Tuesday, August 17, 2021 8:40 AM
To: Works-Wright, Jamie
Subject: FW: Mental Health Commission presentations - Please Kindly Reply with your interests

Please see the email below from Margaret

Jamie Works-Wright
Consumer Liaison
Jworks-wright@cityofberkeley.info
510-423-8365 cl
510-981-7721 office

From: Margaret Fine <margaretcarolfine@gmail.com>
Sent: Monday, August 16, 2021 2:45 PM
To: Works-Wright, Jamie <JWorks-Wright@cityofberkeley.info>
Subject: Mental Health Commission presentations - Please Kindly Reply with your interests

Hi Jamie,

Would you kindly send this email to the Mental Health Commissioners?

Hi All,

I would like to ask for your interests in presentations at our monthly Mental Health Commission meeting and a brief summary about a topic's relevance.

If you would kindly reply with them, I would appreciate it. I will compile the list and get back to everyone.

Here are topics I have received:

1. Services for People with Serious Mental Illness (SMI) and Substance Use Disorder (SUD) provided by the Division of Mental Health, especially regarding homelessness and housing (see notes below).

2. Having a NAMI representative come and talk about the role of family members and caregivers, including in diverse communities. The NAMI meetings at the East Bay Chapter mainly focus on family members and caregivers (based on attending) although NAMI does much more work to help people. Here is the national organization link for more info: https://nami.org/Home

3. Harm Reduction and Substance Use for People with SMI and SUD. The Division is currently working on contracting SUD services and the role of harm reduction is key to having a successful program. It is also important to inform the SCU as it is a critical opportunity to engage using harm reduction principles. We could extend an invitation to the Harm Reduction Coalition, Berkeley NEED or another organization. Lifelong Medical Street Team provides MAT for people in the field.

Division of Mental Health and Clients with Housing Challenges and/or Experiencing Homelessness

1. The Homeless FSP (Full Service Partnership) is an intensive outpatient mental health program with behavioral health clinicians and targeted case managers for clients experiencing housing instability and homelessness at the Division of Mental Health. This program is designed for clients at the highest level of care.

There is a budget allocation of $1,176,437 under the Mental Health Services Act (MHSA) for FY 21/22, in addition to Medi-Cal reimbursement.

2. The Division of Mental Health also has a housing coordinator for the clients, although there is no longer a Homeless Outreach Treatment Team (HOTT).

3. There is a proposed MHSA INN Homeless Encampment Wellness Project and there will be a public hearing on this project in December, 2021 or January, 2022. The program has a budget allocation of $560,000. The Mental Health Commission can submit recommendations.

4. The Medi-Cal CalAIM reforms will change the nature of public health insurance benefits to include housing supports, effective January, 2022 for people with serious mental illness and substance use disorder.

5. The Division of Mental Health has not compiled the data for all clients about their housing status, and moreover developed overarching strategies to support housing stability, maintenance and sustainability based on such data.

I look forward to hearing from you.

Best wishes,
Margaret

Margaret Fine
Cell: 510-919-4309

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Wednesday, August 11, 2021 8:36 AM
To: Works-Wright, Jamie
Cc: Grolnic-McClurg, Steven; Warhuus, Lisa
Subject: FW: CalAIM Explained: A Five-Year Plan to Transform Medi-Cal - California Health Care Foundation

Please see the email below from Margaret Fine

Jamie Works-Wright
Consumer Liaison
Jworks-wright@cityofberkeley.info
510-423-8365 cl
510-981-7721 office

From: Margaret Fine <margaretcarolfine@gmail.com>
Sent: Tuesday, August 10, 2021 10:31 PM
To: Works-Wright, Jamie <JWorks-Wright@cityofberkeley.info>
Subject: CalAIM Explained: A Five-Year Plan to Transform Medi-Cal - California Health Care Foundation

Hi Jamie,

I hope you're doing well. Would you kindly forward this email to the Mental Health Commissioners with copies to the Mental Health Division Manager and the Director of Health, Housing and Community Services?

Hi All,

As some know, there will be implementation of major Medi-Cal reforms beginning January 2022, including for people living with serious mental illness (and co-occurring substance use disorder). There are also specific reforms designed to address homelessness and to provide housing supports "in lieu of services." The California Health Care Foundation developed these materials, which are useful to become familiar with them.

Best wishes,
Margaret

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Monday, August 9, 2021 12:46 PM
To: Works-Wright, Jamie
Subject: FW: MHAB Executive Committee Meeting 8/12/2021
Attachments: MHAB Executive Committee Agenda 08-12-2021.pdf; Executive Committee Minutes 2021 7-08 UNAPPROVED.pdf

Please see the email below

Jamie Works-Wright
Consumer Liaison
Jworks-wright@cityofberkeley.info
510-423-8365 cl
510-981-7721 office

From: MHB Communications, ACBH <ACBH.MHBCommunications@acgov.org>
Sent: Monday, August 9, 2021 12:44 PM
Subject: MHAB Executive Committee Meeting 8/12/2021

Good afternoon,

Please find attached agenda/minutes and meeting information below for the MHAB Executive Committee Meeting on Thursday, 8/12/2021.

Please join my meeting from your computer, tablet or smartphone.
https://global.gotomeeting.com/join/985996269

You can also dial in using your phone.
United States: +1 (571) 317-3116

Access Code: 985-996-269

Join from a video-conferencing room or system.
Dial in or type: 67.217.95.2 or inroomlink.goto.com
Meeting ID: 985 996 269

Or dial directly: 985996269@67.217.95.2 or 67.217.95.2##985996269

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Asia Jenkins
Alameda County Behavioral Health Care Services
2000 Embarcadero, Suite 400
Oakland, CA 94606-5300

Tel: (510) 567-8131
Email: Asia.Jenkins@acgov.org
QIC: 22711

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

Alameda County
Mental Health Advisory Board

Mental Health Advisory Board Agenda

Executive Committee

Thursday, August 12, 2021 ◊ 3:30 PM – 5:00 PM

This meeting will be conducted exclusively through videoconference and teleconference

https://global.gotomeeting.com/join/985996269

Teleconference: 1-571-317-3116, Access Code: 985-996-269

Committee Members:	**Lee Davis** *(Chair, District 5)*; **L.D. Louis** *(Vice Chair, District 4)*; **Marsha McInnis** *(District 1)*; **Brian Bloom** *(District 4)*; **Juliet Leftwich** *(District 5)*

3:30 PM **Call to Order** ..... Chair Lee Davis

3:30 PM **I. Roll Call/Introductions**

3:35 PM **II. Approval of Minutes**

3:40 PM **III. Discussion Items**

A. Future Agenda Items for MHAB

August, September, etc. Meeting Ideas

a) DOJ Report
b) Incompetent to Stand Trail (IST) Program
c) LPS return to local treatment issue
d) JIMHT Report follow-up
e) NAMI presentations (Adult Committee?)
f) Housing, Homelessness & SMI
g) Care First, Jail Last Committee Composition (Criminal Justice Committee?)

B. ACBH Monitoring Framework (Ad Hoc Committee meeting 8/10/21 – 3:30pm)

C. Elections

V. MHAB Staff Report

A. Annual Banquet Update
B. Website Update

4:55 PM **VI. Public Comment**

5:00 PM **VII. Adjournment**

Alameda County
Mental Health Advisory Board

Executive Committee UNAPPROVED Minutes
Thursday, July 8, 2021 ◊ 3:30 PM – 5:00 PM
2000 Embarcadero Cove, Suite 400, Oakland

Teleconference Meeting

Committee Members:	☒ **Lee Davis** *(Chair, District 5)*; ☒ **L.D. Louis** *(Vice-Chair, District 4)*; ☒ **Brian Bloom** *(District 4)*; ☒ **Juliet Leftwich** *(District 5)*; ☒ **Marsha McInnis** *(District 1)*
ACBH Staff:	☒ **Karyn Tribble** (*ACBH Director);* ☐ **James Wagner** (*ACBH Deputy Director)*; ☒ **Dainty Castro** *(Administrative Liaison)*; ☒ **Angelica Gums** *(Secretary II);* ☒ **Asia Jenkins** *(Office of the ACBH Director)*

Meeting called to order @ 3:30 PM by **Chair Lee Davis**.

ITEM	DISCUSSION	DECISION/ACTION
Roll Call	Roll Call completed.	
Approval of Minutes	Minutes approved.	
Discussion Items	A. Future Agenda Items for MHAB July, August, September, etc. Meeting Ideas a) DOJ Report The DOJ Report will continue to be discussed at the Criminal Justice Committee meeting before bringing to the MHAB main meeting. b) Incompetent to Stand Trail (IST) Program Plan to discuss the IST Program in the Criminal Justice Committee Meeting. Committee to invite Yvonne Jones, Cathy Lampi, and Penny Bernhisel to give an overview and transition of the program. This could be presented and discussed at the August CJC meeting. CJC could ask for data, the referral process for the program, why individuals are refused from the	The Criminal Justice Committee for July 21,2021 will be cancelled. The next meeting will be in August 18, 2021. Dainty to send a cancellation for July meeting. Once presented at the CJC, bring back to the full MHAB main meeting. Julie and Brian to discuss the details.

ITEM	DISCUSSION	DECISION/ACTION
	program. Could also invite Warren Ko from the courts, the PD and DA. c) Draft Bylaws The draft Bylaws a will be discussed at the July MHAB Main Meeting. d) Draft Annual Report The draft Annual Report will be discussed at the July MHAB Main Meeting. B. Discuss Draft Bylaws Member Leftwich has incorporated all the recommendations made by the MHAB into the bylaws. There was a discussion regarding officer terms, committee recommendations, and non-voting members. Two-thirds of the members need to vote to make any changes to the bylaws. C. Discuss Draft Annual Report The Annual Report to include a brief paragraph regarding the DOJ Report, will also include information about the MAHB special meetings and correspondences sent on behalf of the MHAB. D. ACBH Monitoring Framework (Ad Hoc Committee meeting July 6, 2021 - 3:00pm to 4:30pm) E. Elections Member Loren Farrar will lead the Ad Hoc Committee for the Elections. Executive Members agreed to hold elections in September 2021. F. Requests for ACBH Director Report Items a) Care First, Jail Last Resolution (Committee Composition Update) Dr. Tribble will present on the initial recommendation from Supervisor Carson, and how the department plans to approach the recommendation. Feedback has been received from various	Dr. Tribble to give report at MHAB main meeting.

ITEM	DISCUSSION	DECISION/ACTION
	advocacy groups. This will need to go back to the Board of Supervisors. b) Budget Update – ACBH Funding and the $50 Million Budget Request The full budget was passed by the Board of Supervisors. The ACBH Budget has increased to $527 million. The BOS directed the HCSA Director to meet with the CAO's office to identify $8.56 million for the medium-term goals for the Forensic Plan that was submitted to the BOS. c) LPS Conservatorship Member Bloom would also like a report out on the LPS Conservatorship at the MHAB main meeting.	Dr. Tribble to give report at MHAB main meeting. Dr. Tribble to give report at MHAB main meeting.
MHAB Staff Report	A. Annual Banquet Update The venue is now allowed to host events at maximum capacity, all restrictions have been lifted. A tentative reservation for October 14th is still being held, however, a contract does need to be signed by August 1st. Executive Committee discussed to postpone banquet, and host banquet in May 2022. B. Website Update	Schedule an Ad Hoc Committee to plan for the Annual Awards Banquet.
Public Comment	Public Comment was given.	
Adjournment	Adjourned at 5:06 PM	

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Wednesday, August 4, 2021 9:29 AM
To: Works-Wright, Jamie
Cc: Grolnic-McClurg, Steven; Warhuus, Lisa; Klatt, Karen
Subject: FW: Qualitative Studies by Ppl w/SMI & Homelessness to Assess Program Design
Attachments: Homelessness & Serious Mental Illness.pdf

Hello all,

Please see the email below for Margaret Fine, MHC Chair

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From: Margaret Fine <margaretcarolfine@gmail.com>
Sent: Tuesday, August 3, 2021 10:45 PM
To: Works-Wright, Jamie <JWorks-Wright@cityofberkeley.info>
Subject: Qualitative Studies by Ppl w/SMI & Homelessness to Assess Program Design

Hi Jamie,

Would you kindly send this research to the Mental Health Commissioners, MHSA Coordinator Karen Klatt, the Division of Mental Health Manager Steve Grolnic-McClurg and the Director of Health, Housing and Community Services Dr. Lisa Warhuus?

Hi Everyone,

As you know, the Division of Mental Health has proposed an MHSA INN Homeless Encampment Wellness Project with a budget allocation in the amount of $560,000.

Attached is substantial qualitative research (basically a literature review) from many studies focused on 1st person

accounts from people who are living with serious mental illness and homelessness.

This research may prove useful to inform program design so the services offered are tailored to meet the needs of people with serious mental illness who are homeless. Also, we need to consider a diverse range of people with co-occurring SMI and SUD and harm reduction services as well.

The MHSA Coordinator Karen Klatt further provided the MHSA INN Homeless Encampment Wellness Stakeholder Report and MHSA INN Proposal by the commissioned consultant, Research Development Associates (RDA) last week.

All of these materials together can be used to assess the merits of the proposed program design, particularly to review if they serve people with SMI and SUD in improving their quality of life—both short and long-term.

It is also suggested to consider overall coordination of services and collaboration among government agencies and CBOs in the program design (beyond referrals and linkages) in order to ensure meaningful follow-up to next step in care (such as peer support specialists/navigators, transportation and support at appointments).

The contracts are also publicly available if of interest. Let us know. Thanks.

Best wishes,
Margaret

Margaret Fine
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Sent from my iPad

Coping amidst an Assemblage of Disadvantage: A Qualitative Metasynthesis of First-Person Accounts of Managing Severe Mental Illness while Homeless

Abstract

Introduction

An evidence gap concerning the impact of extreme socio-structural disadvantage, such as homelessness, on the nature and effectiveness of coping with severe mental illness (SMI) persists. While existing reviews of qualitative research into homelessness have focused on processes such as escaping homelessness and managing concurrent problem substance use, as well as on the experiences of specific vulnerable groups with as women and youth, no analogical review has been dedicated to the management of SMI during an episode of homelessness.

Aim/Question

A qualitative metasynthesis of first-person accounts was conducted to understand how individuals cope with SMI when experiencing homelessness.

Method

The systematic search strategy yielded 481 potentially eligible sources. Following a team-based full-text screening and a two-tiered quality appraisal procedure, 14 studies involving 377 participants with lived experience were synthesized following Noblit and Hare's metaethnographic method.

Results

Seven third-order concepts were derived capturing the complex nature and processual character of coping, as well as the contextual influences upon coping strategies. The resultant line-of-argument synthesis reveals the dialectical interaction between the two higher-order constructs- '*the continuum of coping'* and '*the assemblage of disadvantage'*.

Discussion

Despite the profoundly adverse impacts of biographical and socio-structural conditions, many individuals mobilised internal and external resources to enable various coping processes. Coping in the context of multiple disadvantage is not a monolith but rather a multidimensional, contingent and fluid phenomenon.

Implications for Practice

Nursing practice should espouse a humanizing, structurally competent, and strengths- and meaning-oriented approach in order to meet the complex and multifaceted needs of such multiply disadvantaged persons.

Keywords: serious mental illness; homeless; coping; disadvantage; qualitative synthesis

Accessible Summary

What is known on the subject:

- Understanding what strategies individuals use to cope with serious mental illness is vital for enhancing their quality of life, mental well-being, and effective use of services, and for supporting their mental health recovery;
- An episode of homelessness can be a profoundly disruptive event that often leads to chronic stress, social isolation, a negative belief about oneself, restricted access to care, among other adverse experiences;

What the paper adds to existing knowledge:

- In contrast to existing reviews of qualitative research focusing on escaping homelessness, managing problem substance use and growing resilience, the current review offers an in-depth, interpretive account of coping with serious mental illness during an episode of homelessness;
- This paper integrates evidence showing the diverse and intricate processes via which homelessness can impede an individual's ability to successfully cope with life stressors, including with serious mental illness;

- Despite experiencing severe social disadvantage, many individuals demonstrate positive adaptation and coping, and even personal growth;

What are the implications for practice:

- It is important to be aware of the many ways in which coping with serious mental illness can be influenced by adverse environmental factors such as poverty, homelessness, traumatic life experiences, and institutional discrimination;
- Nursing practice should recognize that coping efforts in individuals facing multiple forms of social disadvantage may be shaped by particular life events, institutional interactions as well as by the stresses and strains of living on the streets;
- Nursing practice should focus not only on reducing clients' mental illness symptoms and facilitating positive coping behaviours, but also on encouraging clients to leverage inner resources for personal growth and meaning-making.

Relevance to Mental Health Nursing

This review paper has direct relevance to nursing practitioners who seek to deliver holistic and person-centred care that meets the complex and multifaceted needs of persons with serious mental illness that are experiencing an episode of homelessness. This paper offers an insightful integration of qualitative research evidence on the various and profound ways in which homelessness (among other forms of structural disadvantage) impedes one's resources and opportunities for positive and successful coping with serious mental illness. This paper hopes to increase nursing practitioners' knowledge of how to best support those multiply marginalised individuals' symptom management, personal growth, and holistic well-being.

Introduction

Research into coping with illness symptoms and the impact of coping on daily functioning in individuals experiencing serious (or severe) mental illness (SMI) has resulted in the prolific generation of various typologies of coping 'strategies', 'styles', and 'resources' (Phillips et al., 2009; Roe et al., 2006; Skinner et al., 2003; Meyer, 2001). For instance, Phillips and colleagues' (2009) systematic review revealed a multitude of coping strategies that individuals with psychosis flexibly mobilise, often simultaneously, to cope with their illness symptoms as well as with the general demands of daily life. Those strategies span general predispositions (coping styles) and situation-specific and often reactionary responses to illness-induced stress (coping responses and strategies). Other reviewers have typologised coping efforts according to their temporal ordering relative to the stressor (e.g. reactive, anticipatory and preventive coping; Roe et al., 2006), their dimension (e.g. emotion- and problem-focused coping; Schwarzer & Taubert, 2002), and the degree of change that occurs within the individual as a result of coping (e.g. assimilative and accommodative coping; Schwarzer & Taubert, 2002).

The abundance of psychological theorising underscores the significance of coping for understanding not only the complexity of the lived experience of service-users, but also for enhancing intervention effectiveness and the quality of care. For instance, Kravetz and Roe (2007) view coping as '*a potentially empowering activity that is a major part of the behavioral and experiential repertoire of individuals with SMI'*. (p. 337), while Yanos and Moos (2007) emphasize coping as one of the crucial determinants of good quality of life among people with schizophrenia. Others have highlighted research into service-users' individual strengths and coping resources as integral to person-centred interventions that build upon service-users' own assets and capabilities (Cleverley & Kidd, 2011; Kidd, 2003). Successful coping strategies have been shown to enhance the individual's psychological resilience against adverse life events (e.g. Lindsay et al., 2000; Cronley & Evans, 2017, for a review). Furthermore, the empirical focus on coping behaviours has shown potential for identifying a range of health-promoting resources- both intrinsic (e.g. inner strengths, abilities and attitudes) and extrinsic (e.g. informal and formal support systems; Kidd, 2003, for a review; Cronley & Evans, 2017, for a review; Thompson et al., 2016).

Crucially, the nature and effectiveness of coping strategies tend to vary from individual to individual, with ineffective and potentially harmful coping strategies (sometimes termed '*maladaptive'*)- such as substance use as self-medication for mental illness symptoms, behavioural disengagement, self-distraction, and others-receiving substantial empirical attention (e.g. Moore, Biegel, & McMahon, 2011). Many maladaptive coping strategies have been associated with a range of adverse outcomes such as symptom relapse, non-adherence to formal treatment, self-harm, low quality of life, and others (Aldao & Nolen-Hoeksema, 2012). Understanding the nature of coping mechanisms is therefore imperative for optimizing individuals' engagement in services, treatment effectiveness and general social functioning (Thompson et al., 2016).

Research into coping with SMI amidst profoundly *disempowering* conditions such as severe poverty and homelessness, however, has been markedly scarcer. Living with multiple, mutually reinforcing forms of socio-economic disadvantage is often synonymous with a '*unique and complex experience of marginalisation'* (Kramer-Roy, 2015, p. 1209). Persons with SMI who are homeless, in particular, often have multiple and complex needs, for instance, in terms of their increased susceptibility to self-harm, social isolation, interpersonal violence, illicit substance use, discrimination, physical health problems, offending, institutionalisation, and others (Scottish Executive Social Research, 2007; McCay et al., 2010). Importantly, such adverse life experiences have been shown to undermine those individuals' capacity to meet the demands of both illness-related and general life stressors (McDonagh, 2011; United States Interagency Council on Homelessness, 2015; Padgett et al., 2008).

Although there is a considerable amount of empirical literature on *general* coping strategies and mechanisms (e.g. Phillips et al., 2009), markedly less is known about *how* those coping processes manifest themselves in the context of severe poverty and/or homelessness (Klitzing, 2003; Gottlieb, 1997; Tischler et al., 2007; Washington & Moxley, 2008). The dominant theorising in the field, commonly rooted in a reductionist, psychologised view of coping, has been criticized for neglecting the socio-structural contexts, and the associated inequalities, that may undermine individuals' ability to mobilise resources for coping (Potter et al., 2018). As Potter and colleagues (2018) note, *'While coping may appear to happen on a personal level, as an ongoing process coping emerges through people's interactions with their*

social and cultural environments.' (p. 140). Ethnographic and other qualitative empirical investigations of how SMI is experienced and managed amidst homelessness offers the crucial opportunity to (re)contextualise the process of coping as *'woven into the tapestry of life'* (Gottlieb, 1997, p. 10) for individuals impacted by structural disadvantage and chronic life stressors (Klitzing, 2003; Ungar, 2012; Yanos & Moos, 2007; Ryan et al., 2014).

The unpredictability, chronicity, and graveness that commonly characterize the experience of homelessness are likely to pose profound challenges to the effective coping with, and recovery from, SMI (Padgett et al., 2012; 2016; Yanos, 2007; Klitzing, 2003; Gottlieb, 1997). Several lines of research have demonstrated the profoundly negative effects of extreme poverty and homelessness on vital enablers of positive coping, including mental health recovery (Kirkpatrick & Byrne, 2009), a positive self-concept (Padgett, 2007), social connectedness (Padgett et al., 2008), hope (Kirst et al., 2014), self-esteem, and self-efficacy (Watson & Cuervo, 2017).

Rationale

While existing reviews of qualitative research into homelessness have focused on resolving and transitioning out of homelessness (Finfgeld-Connett, 2010; Iaquinta, 2016); the management of concurrent problem substance use (Finfgeld-Connett et al., 2012); the experiences of women (Finfgeld-Connett, 2010; Phipps et al., 2019); and the phenomenon of resilience in homeless youth (Cronley & Evans, 2017), no analogical QES has been dedicated to the management of SMI. A systematic review of qualitative and other idiographic research with marginalised, 'hard to reach' and other groups experiencing intersectional disadvantaged (for instance, based on disability status, housing status, socio-economic status, and so on) holds promise for revealing the often hidden complexity of living with severe and multiple disadvantage (Phipps et al., 2019). Amidst persistent calls for enhanced interprofessional practice with people experiencing severe and multiple disadvantage, a QES of studies with homeless populations from within the fields of social work, public health, nursing, and psychiatry seems timely (Duncan & Corner, 2012).

Review Question, Aims and Objectives

Motivated by this recognition of the importance of the context-sensitive investigation of coping processes, especially in multiply disadvantaged populations, a qualitative evidence

synthesis (QES; Aguirre & Bolton, 2014; Walsh & Downe, 2005) was undertaken to generate an enhanced, integrative and systematic understanding of ***how individuals cope with SMI when experiencing homelessness*** (the review question). To our knowledge, this is the first published attempt to systematically synthesize original qualitative and mixed-method research into first-person accounts of coping with SMI during an episode of homelessness.

Methods

The current work adhered to the Enhancing Transparency in Reporting the Synthesis of Qualitative Research (ENTREQ) guidelines (Tong, Flemming, McInnes, Oliver, & Craig, 2012).

The synthesis methodology is *qualitative metasynthesis*- a systematic, inductive and interpretative approach to synthesising the findings from empirical qualitative studies (Zimmer, 2006; Walsh & Downe, 2005; Jensen & Allen, 1996). Although variations exist in the techniques used to conduct a metasynthesis, common analytic steps in this approach are '*…a comparison, translation, and analysis of original findings from which new interpretations are generated, encompassing and distilling the meanings in the constituent studies…'* (Zimmer, 2006, p. 312). The final phase of a meta-synthesis typically involves synthesizing the translations to elucidate more refined meanings, theories, and concepts (Walsh & Downe, 2005), and even to inform health and social policy (Zimmer, 2006). The final, 'synthetic' product represents a third-order interpretation-that is- '*… the synthesist's interpretation of the interpretations of primary data by the original authors of the constituent studies…'* (Zimmer, 2006, p. 313).

The current review employed the analytic steps essential to Noblit and Hare's (1988) metaethnography (see 'Data Analysis Strategy'). The data analysis in the current review was also informed by more recent guidance on conducting a metasynthesis (Atkins et al., 2008; Campbell et al., 2012; Lee et al., 2015).

The underpinning epistemology was *objective idealism*, which assumes that there is a world of collectively shared understandings (Barnett-Page & Thomas, 2009; Kearney, 1998). This philosophical positioning remains faithful to the core tenets of the interpretive paradigm,

while allowing for the meaningful integration of qualitative findings from diverse research contexts and empirical traditions (Zimmer, 2006).

Search Strategy

A pre-planned comprehensive search of five electronic databases (Scopus, PsycINFO, MEDLINE, CINAHL Plus and Social Services Abstracts) was conducted. The search utilized broad-based, free-text terms (e.g. *'experience'; 'homeless/ness'; 'mental';* Shaw et al., 2004) and methodological filters (e.g. *'qualitative', 'mixed*', 'ethnograph*', 'interview*'*), in conjunction with qualitative research indices, where available (e.g. *'qualitative studies', 'qualitative research', 'qualitative methods', 'nursing methodology research';* Shaw et al., 2004). The full electronic search procedure can be found in 'Supplementary Files'. In recognition of the inconsistencies of indexing of qualitative research in electronic databases (Booth, 2016; Barroso et al., 2003), to maximise the retrieval of potentially relevant articles, the electronic search was supplemented by bibliographic searches within the eligible studies, citation searches, and bibliographic searches within topical review papers (Finfgeld-Connett, 2010; Seitz & Strack, 2016; Edidin et al., 2012; Cronley & Evans, 2017; Iaquinta, 2016; Finfgeld-Connett et al., 2012).

Inclusion Criteria

Eligible studies were published in or after 1994 (the year when the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders was introduced), in the English-language and represented original peer-reviewed empirical qualitative or mixed-method articles. In addition, all participants had to be 18 years of age or older, with a history of an SMI diagnosis (either self-reported or independently verified) and be defined as homeless at the time of data collection (unless the study features retrospective accounts of homelessness). Also, all included studies needed to fulfil a set of quality assessment criteria (See below). Non-empirical documents (e.g. conceptual papers, policy papers, review-type papers, commentaries) and unpublished studies were excluded. Finally, to ensure sufficient alignment with the review question (operationalized as the 'conceptual clarity' criterion; See 'Quality Appraisal'), eligible studies had to contain at least one theme addressing the experience of SMI, particularly the coping process. To optimize the inclusion of diverse representations of the phenomenon under inquiry (Jensen & Allen,

1996), *coping* was operationalized broadly as the conscious efforts to ameliorate and/or prevent the negative influences of SMI requiring the cognitive appraisal of a stimulus as problematic or threatening, the conscious assessment and mobilization of available resources for coping, and a commitment to coping action (Folkman & Lazarus (1988), as cited in Andersson & Willebrand (2003).

Abstract Screening and Full-Text Review

A team-based approach to the screening, full-text review and quality appraisal was implemented to enhance the rigour of the review process. The search and screening phases took place between December 2017 and February 2018. The literature review software, Covidence™ (http://www.covidence.org), was used to facilitate the title and abstract screening and full-text eligibility appraisal. The main electronic search was split between the first and the third authors. The full-text eligibility appraisal was carried out by all three authors. To progress through to the quality appraisal stage, each study had to be voted in independently by two of the authors. Covidence™ facilitated the inter-rater agreement and conflict resolution. Any voting conflicts were resolved at periodic team meetings.

1035 documents were imported for screening (1024 documents retrieved from electronic databases, and 11-from bibliographic searches; See 'Figure 1'). After duplicates were removed, 481 studies remained for full-text eligibility assessment. 462 of those studies were excluded from the review due to not meeting the eligibility criteria (See 'Figure 1', for a breakdown of the reasons for exclusion). As a result, 19 studies that fully met the inclusion criteria were progressed through to the quality appraisal stage: Baldwin (1998); Bonugli et al. (2013); Gopikumar et al. (2015); Illman et al. (2013); Jensen (2017); Johnson et al. (2013); Kirkpatrick & Byrne (2009); Leipersberger (2007); Luhrmann (2008); Macnaughton et al. (2016); Muir-Cochrane et al. (2006); Patterson et al. (2012); Paul et al. (2018); Shibusawa & Padgett (2009); Stanhope & Henwood (2014); Stolte & Hodgetts (2015); Voronka et al. (2014); Wharne (2015); Zerger et al. (2014).

Quality Appraisal

A two-pronged approach to quality appraisal that operationalized 'quality' as the combination of adequate methodological rigour and adequate conceptual clarity was followed (Toye et al., 2013;

Malpass et al., 2009). The rationale behind quality appraisal being a determinant for inclusion is based on the assertion that studies of low quality are less likely to meaningfully contribute to the synthesis output and are likely to undermine the trustworthiness of the overall review process (Malpass et al., 2009; Campbell et al., 2012). Methodological rigour was assessed using an adapted version of the RATS (Relevance, Appropriateness, Transparency and Soundness) screening tool (Clark, 2003; 'Supplementary Files'). The RATS scale consists of 21 items, which can collectively yield a maximum score of 42. The threshold for adequate methodological rigour was set as 14 (Clark, 2003). Initially, a random selection of five of the included studies was allocated a methodological score by each author. Inter-rater agreement was assessed to be adequate (The pairwise correlations between the authors' RATS scores were 0.79; 0.99; and 0.77, respectively). Based on those estimates, it was decided that the remaining 14 studies would be split evenly and distributed among the three authors and would require only one score.

Adequate conceptual clarity of the studies that make up the metasynthesis is essential for enabling an enhanced integrative interpretation of the phenomenon of interest (Campbell et al., 2011; Toye et al., 2013; Toye at l., 2014). We operationalized conceptual clarity as the presence of a sufficient number of 'intelligible concepts' or 'metaphors' (Noblit & Hare, 1988) that could facilitate the understanding of the phenomenon under study as well as theoretical insight (Toye et al., 2013). All three authors independently assessed all 19 studies for conceptual clarity, assigning a score of two (high), one (acceptable) or zero (low) to each study. An adequacy threshold of a cumulative score of three was used.

As a result of the two-step quality appraisal process, two studies, Baldwin (1998) and Wharne (2015), were excluded due to low methodological rigour (i.e. <14 total RATS score). Another three studies, Kirkpatrick and Byrne (2009), Johnson et al. (2013), and Macnaughton et al. (2016), were excluded due to inadequate conceptual clarity. As a result, 14 studies were selected for inclusion in the metasynthesis (See 'Figure 1').

[Please insert 'Figure 1' here]

Data Analysis Strategy

The following four-step data analysis procedure was based on Noblit and Hare's (1988) guidance. In 'Step One', an exhaustive list of descriptive inductive codes was generated via line-

by-line coding of the Results/Findings sections of the included studies. The first-order (i.e. participant quotes) and second-order (the interpretations of the authors of the original studies) in each paper were extracted and coded together. Several of the paper used participant quotes sparingly-in those cases, the analysis relied primarily on the findings presented by the authors in the original studies. The coding was restricted to the results/finding section since the inclusion of the 'Discussion' sections would likely have introduced theoretical concepts and findings from other studies thus conflicting the idiographic, bottom-up logic of the metasynthesis.

The aim of 'Step One' was to identify and extract 'intelligible' metaphors, concepts, phrases and ideas that faithfully captured the original meanings of the primary data (Noblit & Hare, 1988; Toye et al., 2014). This was achieved by a process of open coding whereby the researcher creates categories of meaning corresponding to a unit of information in the primary studies (Creswell, 1998). Each unit of information represented a component of the phenomenon of interest (i.e. the experience of and coping with SMI). Codes could be in-vivo codes (i.e. the actual words used by the participants themselves, or by the authors of the primary studies) or descriptive codes that closely resembled the primary data. Examples codes include those related to a specific coping strategy *(*e.g. *'seeking refuges and sanctuaries to manage mental well-being';*(Stolte & Hodgetts, 2015)-coded as *'seeking refuges and sanctuaries'*, and subsequently placed under the 'coping behaviours' category; See 'Table 1'); to an aspect of the context that is relevant to coping (e.g. *'negative social attitudes');* or to a belief about oneself or about one's life that had relevance to whether and how one coped with SMI (e.g. *'hope for the future and appreciation for life'*; Bonugli et al., 2013). This step required constant reflectivity on part of the researcher as to the relevance of the data to the coping experience.

'Step Two' followed the principle of *reciprocal translation* (Noblit & Hare, 1988), whereby substantive analogies among the initial codes were drawn based on thematic relatedness. This step entailed progressively transforming codes into a higher degree of conceptual abstraction resulting in the development of a set of *third-order constructs* (a third-order interpretation of the participants' accounts) that helped capture the 'essence' or totality of the extracted data in an economic and insightful way (Toye et al., 2014). This process resembled Noblit and Hare's (1988) step of *metaphoric reduction*. A translation table (See 'Table 1', for the

translation table) was constructed demonstrating the derivation of third-order constructs from the original data.

'Step Three' involved assessing the adequacy of the initial list of third-order constructs. This was achieved by iteratively de-contextualizing and re-contextualizing the third-order constructs by developing and re-examining a concept-context matrix (see 'Table 2'). This technique helped preserve '*essential contextual information*' as the analysis progressed (Britten et al., 2002, p. 211; Lee et al., 2015).

The authors also remained vigilant of instances where the concepts were challenged or contradicted (*refutational synthesis*; Noblit & Hare, 1988). No apparent contradictions were identified among the concepts extracted from the individual studies. Instead, each study's findings illuminate a different aspect of the third-order constructs. In other words, the concepts derived from the included studies had a reciprocal and a line-of-argument relationship among them (France et al., 2014).

In 'Step Four', the relationship among the concepts was expressed via a line-of-argument synthesis (Noblitt & Hare, 1988; Lee et al., 2015). The aim was to produce a final narrative or a synthesizing argument that accounts for, and integrates, all the data (Lee et al., 2015), and answers the review question. Also, following Noblit and Hare (1988), we focused on '*making a whole into something more than the parts alone imply'* (p. 28). That is, the synthesizing argument was constructed to express an enhanced, novel and integrative understanding of the phenomenon under inquiry (Noblit & Hare, 1988; France et al., 2014).

NVivo 11 was used to enhance the rigour of the coding process. The initial stages of the data analysis were carried out by the first author. The second and third authors audited the list of concepts and any necessary revisions were made following team discussions. Memoing of all analytic decisions and potential author biases (in the form of an audit trail), in addition to group reflexivity among the authors, was used to further enhance the rigour of the data analysis (Lee et al., 2015). Yet, the metasynthesis is an inherently interpretive process and the current authors have generated one of many possible interpretations of the current data set (Jensen, 1996).

Findings

Overview of the Design Characteristics of the Included Studies

Six of the included studies were conducted in the United States, five-in Canada, and the other three-in India, Australia, and New Zealand (See 'Table 3'). The majority of the studies (eight) employed a traditional qualitative interview-based research design (Note: One study, Stanhope and Henwood (2014), conducted individual in-depth interviews in the context of a community-based participatory programme); three studies used an ethnographic design (including one ethnographic case study design; Stolte & Hodgetts, 2015); and three-a mixed-method design. The predominant data collection tool in the current sample of studies were in-depth individual semi-structured interviews. A minority of studies employed additional data gathering techniques such as participant observation, go-along interviews, photo-elicitation interviews, personal timelines and focus groups. Data analysis techniques of choice included content or thematic analysis (in five studies), grounded-theory based analysis (in four studies), phenomenological analysis (in one study), and non-specified analytic approaches (in four studies; Note: One study, Voronka et al. (2014), used peer-led data analysis).

The total number of participants with lived experience in the current sample of studies is 377 (52% female; Note: One study, Jensen (2017), did not report gender characteristics of the sample). The sample sizes range from one to 61. Participants' housing status varied, including street homeless, and residing in shelters, supportive housing, or permanent and independent housing (for example, Housing First residents). Common mental health diagnoses among the participants included psychotic disorders (such as schizophrenia), major depressive disorder, post-traumatic stress disorder, and others. A summary table of the design components and methodological scores of the included studies can be found in 'Table 3'.

Overview of the Findings of the Metasynthesis

The analysis resulted in the derivation of seven third-order constructs (See 'Table 1', for the translation table), which were grouped into two clusters of higher-order constructs: *continuum of coping* and *assemblage of disadvantage*. Those higher-order constructs were derived after examining the emergent third-order constructs for commonalities and differences among them. It first became apparent that the different manifestation of coping could be 'arranged' along a continuum-from the highly reactive coping as survival to the much more deliberative and reflective coping as meaning-making. The remaining third-order constructs represented the embeddedness of those coping processes in a range of influential contexts-from participants' unique biographies to their shared experience of stigmatization.

1. Continuum of Coping

This cluster of analytic themes begins by examining how the demands for self-preservation deplete internal resources-such as time and focus-required to initiate efforts to cope with the symptoms of mental illness. Next, strategies targeted at ameliorating SMI are distilled, distinguishing between successful and unsuccessful (including maladaptive) coping, and between facilitators of and barriers to coping. Then, participants' personal commitments, priorities and goals are synthesized, which all represent possible sources of motivation for more effective coping. The processes of reflection and meaning-making were also extracted from the data as distinct types of coping. The corresponding third-order constructs are, as follows:

1.1. Survival strategies and adaptations to life on the streets;

1.2. Coping with SMI and its impacts;

1.3. Personal reasons and motivations for coping;

1.4. Reflection and meaning-making;

2. Assemblage of Disadvantage

This cluster of analytic themes captures the multiplicity of what are primarily external influences upon the nature, content and effectiveness of coping with SMI. Specifically, the impact of personal biography, including adverse life events; the impact of structural barriers rooted in

systems of care; and the impact of attitudinal structures such as stigma, are discussed. The corresponding third-order constructs are, as follows:

2.1. Context of early life: Emotional and psychological consequences of traumatic and other adverse life experiences;

2.2. Structural barriers to receiving effective health care and social supports;

2.3. Pervasive complex social stigma and its impact

[Insert 'Table 1' here]

[Insert 'Table 2' here']

[Insert 'Table 3' here]

Survival Strategies and Adaptations, and their Impact on Coping with SMI

The majority of included studies (eight) offered accounts of the stresses and strains of poverty and homelessness, as well as of the adaptations that individuals had developed to self-preserve. Those adaptations referred to various day-to-day tactics and internalised predispositions that ensure (physical) survival and the effective management of general life stressors. Specifically, the chronic stress, precarity, extreme poverty, the exposure to violence and other adverse environmental stressors led some participants to engage in cautionary social distancing, constant vigilance, risk-taking, among other self-preserving strategies (See 'Table 1').

Often, however, the necessary preoccupation with survival and self-preservation *impinged upon* the individuals' efforts required to effectively access and mobilise the resources needed to cope with the symptoms of SMI. For instance, one of Illman et al.'s (2013) participants poignantly stated (p. 218): *'I am not trying to recover now because there's, there's, there's no need, it's survival nowadays is, no conditions, the way the conditions are these days. It's just, it's survival you know.*' Similarly, many of Stanhope and Henwood's (2014) participants discussed the immense difficulties of attending to their health needs amidst severe economic deprivation and housing instability.

For some participants, a profound consequence of homelessness and poverty was social disaffiliation, which had far-reaching effects on those participants' sense of self-worth, on the quality of their social supports, and on their recovery. To demonstrate, Shibusawa and Padgett

(2009) report that: *'Many of the participants struggled with feelings of being out of sync with their "normal" peers. Some attributed this to the severe deprivation of homelessness and accompanying survival mechanisms.'* (p. 192). According to Shibusawa and Padgett's analysis, the stigma and alienation that some participants experienced entrenched their (internalized) feelings of 'abnormality', which, in turn, hindered their efforts to reintegrate into society as productive members.

Tensions and contradictions often emerged between the behaviours and predispositions that were adaptive for living on the streets and those that were adaptive for successfully navigating the health and social services sector and receiving appropriate help. For some of the participants, the aptitudes that have adaptive advantages on the streets (e.g. being tough, displaying strength) were antithetic to those that helped someone benefit from services (e.g. seeking help, developing trust; Luhrmann, 2008; Stanhope & Henwood, 2014; Bonugli et al., 2013). Patterson and colleagues (2012) use the metaphor of 'hardening' to denote some of their participants' social distancing and lack of trust for others due to long-term social exclusion and disadvantage. This is also echoed by one of Luhrmann's (2008) participants: *'You have to keep your guard up at all times…'* (p. 17). In contrast, fully benefitting from peer support entailed sharing personal experiences in an open and authentic manner, as well as forming meaningful bonds with the group members (Stanhope & Henwood, 2014).

Coping with SMI and its Impacts

All 14 studies contained accounts of distinct strategies and other behaviours specifically enacted to manage, mitigate, and/or cope with, the symptoms of SMI. Across those studies, coping manifested itself across various domains-the psychological (or cognitive), the affective, the relational (or interpersonal), and the instrumental (or behavioural) domains. To demonstrate, while some participants emphasized the maintenance of optimism, pride and dignity, and normalized their experience of SMI (e.g. Paul et al., 2018; Gopikumar et al., 2015; Leipersberger, 2007; Bonugli et al., 2013), and identifying productive emotional releases (Jensen, 2017), others tended to report a range of behavioural strategies-such as engaging in peer support (Stanhope & Henwood, 2014), seeking formal help with medication management and seeking refuge (Muir-Cochrane et al., 2016; Stolte & Hodgetts, 2013), and staying active and engaging in various occupational activities (Illman et al., 2013; Stolte & Hodgetts, 2013).

Among the key enablers of effective coping were also achieving emotional stability by (re)gaining control over one's health (e.g. Muir-Cochrane et al., 2006), developing an insight into one's health and life challenges (Paul et al., 2018), rekindling hope (Paul et al., 2018), and maintaining autonomy in daily life (Stolte & Hodgetts, 2013).

Furthermore, the *relational nature* of some of the reported coping behaviours emerged as another prominent aspect of coping with SMI. For instance, some participants tended to cope by searching for an 'anchor' in a significant other in response to feeling powerless (Paul et al., 2018). Similarly, staying connected to one's cultural and communal ties was another helpful response to the burden of SMI (Paul et al., 2018). Other participants found humor (an essentially social activity) to be a useful strategy for tackling the stigma associated with both mental illness and living in a homeless shelter (Jensen, 2017). The interpersonal aspects of coping with SMI are vividly demonstrated by Stanhope and Henwood's (2014) account of the value of peer support to their participants. The participation in peer support groups offered those participants a welcomed sense of connectedness-a common antidote the experience of homelessness. Peer support also aided disclosure and provided assurance, in addition to increasing the participants' knowledge, confidence and sense of empowerment (Stanhope & Henwood, 2014).

Participants' accounts revealed that the enactment and maintenance of the aforementioned effective coping strategies tended to be hindered by a range of internal (e.g. referring to internalized maladaptive predispositions and/or coping responses) and external (e.g. socio-structural) barriers. For some participants, for instance, medication adherence was associated with practical, physiological and psychological barriers. Unsurprisingly, being homeless complicated medication-taking (Muir-Cochrane et al., 2006). Many participants reported substituting psychiatric medications with illicit substances, which served to blunt unwanted thoughts and emotions *(''Cause I didn't care, 'cause I was still using.'*; Leiperberger, 2007, p. 11; Muir-Cochrane et al., 2006; Shibusawa & Padgett, 2009). Other persistent barriers to effective coping include pessimism and hopelessness (Patterson et al., 2012; Zerger et al., 2014; Leipersberger, 2007), minimizing and hiding symptoms from others (Henwood & Stanhope, 2014), the fear of disclosure (Paul et al., 2018), and the lack of knowledge about available resources (Leipersberger, 2007).

Personal Reasons and Motivations for Coping

The participants in almost half (six) of the included studies offered accounts of some of their personal reasons and motivations for coping. The desire to (re)connect with one's 'true' self (Paul et al., 2018; Zerger et al., 2014), to return to normality and to achieve happiness (Leipersberger, 2007), as well as the belief in oneself and the possibility of a positive change (Paul et al., 2018; '*I have a lot more to grow on…*' (Bonugli et al., 2013, p. 833) were discussed by some participants as important drivers of positive coping. For other participants, fostering positive relationships with others-with their community, family and/or children-was a powerful catalyst of coping. For them, the process of social reintegration promised the restoration of their dignity, respect and trust (Zerger et al., 2014; Paul et al., 2018; Gopikumar et al., 2015). In addition, several participants poignantly shared their accumulated wisdom, awareness of their 'time left', the intrinsic volition for a meaningful and satisfying life-beginning to 'live', not just 'exist', and the potential opportunities to spread this wisdom and give back to others, as being important reasons to (continue to) 'do well' (e.g. Shibusawa & Padgett, 2009; Bonugli et al., 2013).

Reflection and Meaning-Making

A small proportion of studies (four or 29%) featured accounts of various reflective and/or meaning-making activities enacted by participants. Meaning-making can be defined as '*a global orientation'* related to the *'pervasive, enduring – though dynamic'* feeling that the individual has that the world is comprehensible, that the future challenges are manageable, and that efforts to overcome those challenges are meaningful and worthwhile (Lundman et al., 2010, p. 252, citing Antonovsky, 1988). Notably, those accounts demonstrate that such meaning-making processes are possible despite the existence of immediate stressors and the profound concerns that the individuals may have about their survival and well-being.

To demonstrate, some participants valued opportunities to pause, reflect and evaluate their past, present and desired future, which brought a sense of purpose, coherence and self-efficacy (Shibusawa & Padgett, 2009). Furthermore, some of Bonugli et al.'s (2013) participants engaged in introspective activities that lead them to rethink their past traumatic experience and nurture a sense of gratitude, reliefs and hopefulness, e.g. '*That leads me to believe that there's a purpose for me ... In this life, you know? And God has allowed me to go through all this stuff...'* (p. 833).

Practising faith and spirituality are other manifestations of such higher-order meaning-seeking activities that emerged from the data (Paul et al., 2018).

Yet, those quests for meaning were not bereft of anxieties and uncertainty. The sense of loss and regret, and the awareness of the finiteness of life caused some participants to experience significant existential concerns, as evidenced in Shibusawa and Padgett (2009).

Context of Early Life: Emotional and Psychological Consequences of Traumatic and other Adverse Life Experiences

This third-order construct captures significant aspects of participants' narratives in four (29%) of the studies. Collectively, adverse life experiences tended to carry profoundly negative social, emotional, psychological and existential consequences for those individuals. To demonstrate, some of Bonugli et al.'s (2013) participants reported a sense of social disconnectedness, hopelessness, powerlessness and unresolved anger, blame and guilt, as a result separation from the family and periods of victimization. Similarly, Patterson and colleagues' (2012) biographical narratives revealed *'[…] trajectories of accumulating risk and marginalization that contributed to their current experience of social devaluation, despair, and constrained choices.'* (p. 141).

The long and deleterious 'reach' of adverse life events is especially evident in some participants' accounts of their *current* despair, emotional pain, emotional disconnectedness, low self-esteem and apathy (Bonugli et al., 2013; Patterson et al., 2012; Gopikumar et al., 2015). Importantly, past traumatic and other negative life events seemed to hinder those individuals' current efforts, strategies and resources available to cope with SMI. For instance, the emotional 'blunting' and the internalized lack of trust in others seemed to prevent some participants' from effectively managing their illness symptoms, in the context of homelessness (e.g. Bonugli et al., 2015). Moreover, the existential loneliness, loss of touch with oneself and the sense of 'uprootedness' appeared to hinder opportunities to create coherence out of life (Bonugli et al., 2013; Patterson et al., 2012).

Structural Barriers to Receiving Effective Health and Social Supports

Numerous structural and systemic barriers located within the healthcare and other public systems negatively affected individuals' coping with SMI-both directly and indirectly- as

evidenced in six (43%) of the included studies (e.g. Voronka et al., 2014; Leipersberger, 2007; Stanhope & Henwood, 2014; Muir-Cochrane et al., 2006). Among the reported barriers to receiving effective mental health support were the restricted access to care due to financial and other structural barriers (Voronka et al., 2014; Muir-Cochrane et al., 2006), the distrust in health professionals (Stanhope & Henwood, 2014), and the humiliation and disrespect experienced as a result of health system encounters (Bonugli et al., 2013). Interactions with service staff were among the main sources of discontent; often, there was a lack of understanding from staff, as well as overt prejudice and discrimination (Voronka et al., 2014; Leipersberger, 2007). Past negative experience and/or anticipated negative encounters (due, for example, to social stigma and/or self-stigma/internalised stigma) were shown by some of the studies to perpetuate the clients' loss of self-worth, their neglected mental health needs and the clients' social disenfranchisement (e.g. Voronka et al., 2014). Furthermore, several participants pointed out that the dominant philosophy of care and institutional practices were unhelpful in their developing self-management skills and a degree of autonomy (Voronka et al., 2014). Some participants emphasized the importance of recovery- and social justice- oriented care, and the caring and responsive stance of services providers (Voronka et al., 2014).

Pervasive Complex Stigma and its Impact

The participants in most (ten out of 14) studies reported experiences of stigmatising attitudes by the general public, by their caregivers, and/or their social networks (Gopikumar et al., 2015; Bonugli et al., 2013; Patterson et al., 2012). Negative social attitudes tended to create alienation and marginalisation*: 'This general feeling of being different, of being an outsider, was a common thread in participants' narratives.'* (Voronka et al., 2014, p. 265). The resultant social distancing impeded mental health recovery (Zerger et al., 2014). Some individuals internalised those negative social beliefs, which motivated continued social distancing and also led to a damaged sense of self, which, in turn, adverse impacted on coping with SMI (Zerger et al., 2014): *'The powerful negative experience of stigma both caused and exacerbated feelings of not being normal…*' (Shibusawa & Padgett, 2009, p. 192).

Furthermore, stigmatization and discrimination tended to occur across various axes of social division-including mental illness, disability, homelessness, gender, race and age (Bonugli et al., 2013; Shibusawa & Padgett, 2009; Gopikumar et al., 2015; Zerger et al., 2014).

Line-of-Argument Synthesis

A 'Continuum' of Coping

Collectively, constructs 1.1-1.4. comprise a '*continuum of coping'*, whereby individuals employ, often simultaneously, adaptive predispositions to maximize self-preservation, and problem- and emotion-focused coping behaviours to optimize illness symptom management, in addition to the processes of reflection and meaning-making to *transcend* the immediate stressors and to achieve a global sense of coherence. This continuum of coping processes is therefore enacted to meet those individuals' multiple and complex needs- ranging from their immediate survival to the higher-order need for meaning and purpose in life. Crucially, the synchronization of those processes has to be achieved while navigating structural barriers-socio-material, attitudinal and ideological.

The Assemblage of Disadvantage

Constructs 2.1-2.3. capture the plethora of structural and biographical influences on participants' coping. Those influences affected coping with SMI both directly-via 'instilling' concrete, often maladaptive, coping strategies, or indirectly-via limiting the resources and opportunities, tangible and intangible, for successful coping. On the whole, the nature and process of coping was shaped by biographical events, institutional interactions, the socio-cultural milieu, as well as by the daily hardship imposed by poverty and homelessness. The '*assemblage*' (borrowing the term from Voronka et al., 2014) of disadvantage constrains the 'continuum of coping' in a multitude of ways.

Altogether, the 'continuum of coping' and the 'assemblage of disadvantage' concepts expand the understanding of the multiplicity and the contextual embeddedness of coping with SMI amidst severe and multiple disadvantage, and demarcate the critical components of the coping process. In particular, the current metasynthesis offers valuable insight into the relationship between influential contextual conditions (e.g. housing insecurity, poverty, responsiveness of services), internal (e.g. self-esteem) and external (e.g. social support) resources for coping, accountings of the motivation for more effective coping (e.g. a desired self; reconnecting with others), and a range of coping outcomes (e.g. negative/maladaptive

coping, successful coping, non-coping). The metasyntesis also identifies a number of contingencies, including the exposure to violence, the depletion of social support, the volatility of life on the streets, and institutionalization, that can profoundly undermine the management of, and the recovery from, mental illness. Such conceptualisation of coping as a multi-determined phenomena offers several potential avenues for interventions by support services aimed at maximizing coping capacities and empowering clients to achieve personally defined, desired outcomes. Ultimately, gaining an in-depth insight into the challenges to sustaining mental well-being, into the sources of vulnerability, into the structural determinants of coping, and into the dynamics of personal growth and recovery, is essential for helping initiate and sustain the mechanisms of change, both individual and societal, that enable better well-being.

Discussion

This metasynthesis sought to generate an enhanced, integrative understanding of how individuals cope with SMI while experiencing homelessness. Despite the relatively small number of reviewed studies (14), the current line-of-argument synthesis offers useful insights into the dialectical interaction between *the continuum of coping* and *the assemblage of disadvantage*, as evidenced through the first-person narratives of individuals with lived experience *and* through the primary studies' authors' interpretations.

Consistent with prior reviews on SMI (e.g. Phillips et al., 2009), the current metasynthesis found evidence of a wide range of coping behaviours. The additional insights offered by the current metasynthesis, however, pertain to the *origins* and *situational variation* of those coping behaviours in people facing an episode of homelessness. Specifically, it was found that the social ecology of 'street life' and that of public institutions tended to engender specific sets of coping responses-both effective and ineffective (including maladaptive ones). For instance, for some participants, the need for self-preservation in what can be a hostile, threatening and uncertain street and/or shelter environment can give rise to avoidance- (e.g. hypervigilance, social distancing, avoiding confrontation) and impression management-oriented (e.g. hiding vulnerabilities, displaying strength) coping strategies. Notably, for some of the participants in two of the studies, those survival behaviours were costly insofar as they diminished internal resources available for successful illness symptom management (Stanhope & Henwood, 2014; Illman et al., 2013). Certain institutional interactions (both experienced and anticipated) also seemed to shape coping behaviours. Several aspects of the attitudinal environment in both the shelter system and the health care system were deemed by some participants as unhelpful, including the lack of compassion and respect and the demeaning attitudes of staff (e.g. Voronka et al., 2014; Leipersberger, 2007; Patterson et al., 2012). Crucially, those adverse structural factors were often associated with stigmatization, which, in turn, tended to undermine the individuals' resources for coping, namely social connectedness, the continuity of care and the sense of self-worth. Among such adverse factors were the increased social marginalization, the

deepening of one's feelings of being abnormal, the 'assaults' on one's dignity, and the diminished prospects of help-seeking (e.g. Zerger et al., 2014; Luhrmann, 2008).

For many people who face concurrent homelessness and SMI symptoms, coping efforts must be enacted in the context of pervasive structural barriers, including complex stigma. Those structural barriers occurred both at the organizational or macro-level (e.g. bureaucratic barriers; Voronka et al., 2014) and the interactional or micro-level (e.g. difficulties in relating to and trusting professionals; Leipersberger, 2007). Importantly, those factors had negative implications for both formal coping (e.g. help-seeking; patient-provider interaction; Muir-Cochrane et al., 2006) and informal coping (e.g. lowered self-esteem; Bonugli et al., 2013). The accounts of many of the participants were imbued with experiences and perceptions of discrimination, marginalization and alienation caused by social attitudes (e.g. Bonugli et al., 2013). The detrimental effects of stigma were reported in terms of increased social distancing limiting the access to formal help; in terms of internalized stigma resulting in a damaged sense of self; and in term of an entrenched feeling of abnormality and deviance, among others (Voronka et al., 2014; Gopikumar et al., 2015). The existence of *intersectional stigma* was accounted for in several of the studies, which show the compounding effects of stigma based on mental illness, female gender, marital status, poverty and homelessness, and ethnicity (Zerger et al., 2014; Bonugli et al., 2013). The accumulating evidence of the effects of intersectional stigma on well-being warrants focused efforts by service-providers and policy-makers to ensure equity of care and outcomes for this underserved population.

In their seminal transactional model of coping, Lazarus and Folkman (1984) purport that coping is situation-bound and cannot be considered in generalized terms. What they fail to consider, however, is that current coping behavior may be (at least partially) borne out by an '*ongoing lifecourse process of adapting and accommodating to […] destabilizing or threatening experiences.'* (Gottlieb, 1997, p. 4). The evidence of the 'rootedness' of present-time coping behaviours within some individuals' life experiences (life history) found in four of the included studies highlights the importance of a biographic approach for enhancing the *person-centred care* for those experiencing multiple disadvantage (McKeown et al., 2006; Padgett et al., 2008; Phillips et al., 2009). Notably, only two (14%) of the synthesized studies (Patterson et al., 2012; Shibusawa & Padgett, 2009) employed a life history approach as their main data collection tool.

Overall, despite the relatively small number of topically relevant studies identified, the metasynthesis explicated the *multidimensionality* of coping with SMI amidst severe deprivation. Coping can manifest itself in seeking stability *and* in making change (Paul et al., 2018; Shibusawa & Padgett, 2009); in the hectic rhythm of routine activity *and* during the quiet moments of reflection (Stolte & Hodgetts, 2013; Shibusawa & Padgett, 2009); in the (in)voluntarty social isolation to preserve the self, *and* in (re)establishing meaningful connections with others (Bonugli et al., 2013).

Finally, despite evidence of the theoretical and analytical utility of salutogenic concepts such as *inner strength* (Lundman et al., 20110), the inclusion of salutogenic concepts in the reviewed studies was markedly scarce. To demonstrate, *mental health recovery* is the main focus of only one study (Gopikumar et al., 2015), and is mentioned by only six (43%) of all included studies. Similarly, the term *(psychological) resilience* is invoked by only five (36%) of the studies, while *(inner or psychological) strength* is featured in four (29%) of the studies. This trend in the current sample of studies reflects the topical literature's preoccupation with vulnerability to the neglect of individuals' strengths and empowerment (Thompson et al., 2016; Thomas et al., 2012; Bender et al., 2007).

Strengths, Limitations and Reflexivity

First, the current metasynthesis was limited in its scope by including studies with adult samples only and with persons with a history of SMI (excluding, for instance, persons experiencing subclinical psychological distress, personality disorders, problem substance use only, and others). Second, to ensure the manageability of the analysis and the adequate methodological rigour of included studies, no gray literature was included. Third, the presence of our focal construct, coping with SMI, had to be subjectively extrapolated from the original accounts, which often proved challenging because of the inherently fluid nature of coping, especially in persons experiencing chronic stress, whereby coping with SMI can become indistinguishable from coping with general life stressors. This concern is echoed by Gottlieb (1997, p. 10), who notes that, in the context of chronic stress, '[…] *it is not meaningful to point to one set of behaviors and cognitions and say that they constitute coping, whereas all the rest is ordinary living.'* Fourth, despite the comprehensive search strategy, a relatively small body of work was

located that met the current inclusion criteria, which seems to reflect the general paucity of research into coping with SMI in this population. However, this raises moderate concerns about the adequacy of the original data (Glenton et al., 2018). For the complete self-assessment of the confidence in the findings of the current metasynthesis, see 'Table 4'.

Future investigations should address the paucity of qualitative and mixed-method research exploring the lived experience of mental illness, including coping, in individuals with a history of SMI who are experiencing homelessness, especially in the U.K (lacking in representation in the current sample of reviewed studies).

Among the strengths of the current review are the comprehensive search strategy, the use of a two-stage quality appraisal strategy that minimized the risk of low-quality studies compromising the credibility of the findings, and the use of software (e.g. Covidence™; NVivo 11), where appropriate, enhancing the rigour and transparency of study screening, data extraction and synthesis procedures. Furthermore, the focal construct, coping with SMI, was purposefully defined broadly when approaching the literature in order to (a) minimise potential biases stemming from favouring any strong theoretical model of coping; and (b) allow 'coping' to emerge organically from the context of each individual study. Last but not least, through the reciprocal translation and the line-of-argument synthesis, the current metasynthesis achieved a relatively high degree of conceptual abstraction and synergy among the concepts of the original studies-thus increasing the potential of the findings to advance theory and inform practice.

Researcher reflexivity is essential for ensuring that the findings of the metasynthesis authentically represent the primary data (Lee et al., 2015). Reflexivity was practiced throughout the current metasynthesis by, for instance, holding regular team meetings to appraise key methodological decisions, and to illuminate any background knowledge and beliefs that might be biasing the review process. Nonetheless, the conduct of a qualitative metasynthesis is an inherently interpretive act; therefore, acute awareness of the potential influence of the reviewers' identities and cultural and disciplinary biases on the findings is warranted. The review team of the current metasynthesis is highly diverse-culturally, geographically, professionally and academically. It is comprised of a Bulgarian male (public health and health policy), an Asian female (social work) and an American female (social work) PhD students, the latter two of whom have had professional social work practice experience with persons experiencing

homelessness and/or mental illness. It is hoped that the diverse composition and expertise of the reviewer team contributed to a nuanced, inclusive and empathetic analytic perspective. Finally, the first author, who led the data analysis stage of the review, had an affinity towards the critical realist philosophy, particularly towards theoretical perspectives of the influence of the structure-agency nexus on mental health phenomena. This philosophical inclination might have inadvertently biased the line-of-argument synthesis.

Implications for Mental Health Nursing

The current metasynthesis elucidates the complexity and interconnectedness of the needs of multiply disadvantaged persons with SMI. Their support needs are likely to be unique, evolving and situated within complex social contexts (Fisher, 2015). The current findings emphasize the need for psychiatric and mental health nursing practice to espouse a (a) *humanizing*, (b) *structurally competent*, and (c) *strengths- and meaning- oriented* approach in order to meet the complex and multifaceted needs of persons with SMI that are experiencing homelessness. To begin with, the current findings exemplify the heterogeneity and uniqueness of the concurrent experience of homelessness and SMI. Moreover, the synthesis explicated various manifestations of human agency, including self-definition, goal-seeking, dignity, expansion of the self and the negotiation of structural barriers, among others. Those findings strengthen the call for humanizing practice in mental health nursing, which should adopt *'an understanding of others' worlds grounded in experiences of real people living through complex situations – the holistic context for understanding quality of life'* (Todres et al., 2007, p. 59; Todres et al., 2009).

Moreover, mental health and psychiatric nursing practice should extend beyond the narrow focus on 'coping efforts' and 'coping skills' as merely intrapsychic phenomena by developing adequate *structural competency* (Metzl & Hansen, 2014). Structural competency broadly refers to being cognizant of the structural and contextual 'forces' that shape clients' interactions with services, and clients' health-related behaviours and experiences more generally (Metzl & Hansen, 2014). Proponents of the strengthening of the structural competency of service-providers insist that '[…] *inequalities in health be conceptualized in relation to the institutions and social conditions that determine health related resources*.' (Metzl & Hansen, 2014, p. 127). As applied to the coping in the context of multiple disadvantage, such an orientation of care provision entails moving beyond the notion of coping with SMI as merely determined by

'internal psychological processes' (Holman et al., 2018, p. 393), and towards coping as at least partially shaped by enduring structural, cultural and contextual conditions. Appropriate nursing care should, therefore, include advocacy for eliminating structural barriers to accessing services and to maintaining positive mental well-being, as one its core missions.

Last but not least, nursing professionals should attempt to *'encompass* [human] *complexity in human lives, needs, desires and existential meaning'* (Kogstad et al., 2011, p. 480), by nurturing the individual's growth potential, in line with the personal recovery philosophy (Slade, 2010; Farkas et al., 2005). Beyond meeting the basic (survival) needs of people who are homeless and have SMI, and enhancing their coping skills, practitioners should attend to those individual's (intrinsic) striving towards meaning, coherence and self-transcendence (Runquist & Reed, 2009). To enhance one's well-being and possibly thrive despite those early life experiences, and their impacts, practitioners should aid service-users in marshalling resources for both coping and self-transcendence (Reed, 1991; Nygren 2005). Rooted in existentialism, self-transcendence entails marshalling of one's ability to concentrate beyond the immediate barriers and limitations (e.g. imposed by SMI symptoms, poverty and/or homelessness) and towards the *'…expansion of one's boundaries inwardly in various introspective activities, outwardly through concerns about others and temporally, whereby the perceptions of one's past and future enhance the present*.' (Nygren, 2005, p. 355, citing Reed, 1991), which, paradoxically can be triggered by vulnerability and adversity (Runquist & Reed, 2007; Roe & Chopra, 2003). An increased research focus on multiply marginalised individuals' own constructions of well-being, personally defined goals and sources of self-determination has the potential to inform holistic and recovery-oriented interventions (Thomas et al., 2012; Roe & Chopra, 2003).

Conclusion

Despite the profoundly adverse impacts of biographical and socio-structural conditions, many individuals with a history of an SMI who are facing an episode of homelessness mobilise internal and external resources to enable various coping and salutogenic processes. Coping in the context of multiple disadvantage is not a monolith but rather a multidimensional, contingent and fluid phenomenon. Qualitative evidence syntheses of the experience of coping with SMI can help

unravel the multiple dimensions and the contextual embeddedness of this dynamic process carrying useful implications for both nursing research and practice.

Conflict of Interest

The authors declare no conflict of interest.

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Table 1: Translation table

Example first- and second-order data (i.e. participant quotes and authors' interpretations in the original studies):	Third-order data (i.e. the metasynthesis authors' interpretations): Descriptive categories (in bold italic) and 'child' codes (in non-italic):
A CONTINUUM OF COPING (a higher-order construct):	
'…hypervigilance was displayed in maintaining heightened awareness…' (Bonugli et al., 2013); 'I am not trying to recover now because…there's no need, it's survival nowadays…It's just, it's survival…' (Illman et al., 2013); 'I don't let people get close to me.' (Bonugli et al., 2013); 'Female interviewees were more apt to talk about social distancing as a survival technique.' (Zerger et al., 2014); 'Many of the participants struggled with feelings of being out of sync with their "normal" peers. Some attributed this to the severe deprivation of homelessness and accompanying survival mechanisms.' (Shibusawa & Padgett, 2009); 'health-enhancing tactics' (Stolte & Hodgetts, 2015); 'Creating a landscape for temporary respite and care' (Stolte & Hodgetts, 2015); 'For many, the reality of life on the streets made it virtually impossible to both prioritize their health over the other challenges they faced and negotiate the logistics of managing their health without stable housing.' (Stanhope & Henwood, 2014)	***Survival strategies and adaptations to life on the streets:*** Survival strategies; constant vigilance; health-enhancing tactics; cautionary social distancing; avoiding conflict and danger; hiding vulnerabilities; risky activities and risk-taking as a necessity; seeking respite in daily life; street smart; the struggle for survival made one feel 'out of sync' with normality; survival displaces foci on recovery and other needs; priority of basic needs; daily survival needs displace recovery; displaying strength
Coping behaviours (Paul et al., 2018); 'seeking refuges and sanctuaries to manage mental well-being' (Stolte & Hodgetts, 2015); 'He claims that these activities and interactions are important to his health and ability to 'stay sane' (Stolte & Hodgetts, 2015); 'repositioning stigma through humour	***Coping with SMI and its impacts*:** Self-management as doing things and staying active; maintaining a sense of autonomy and control; coping as a lifelong process; coping with stigma through dignity and humour; occupational repertoires; maintaining pride; normalising SMI; psychological masking; seeking instrumental support;

(Jensen, 2017); searching for an 'anchor' in a significant other in response to feelings of powerlessness (Paul et al., 2018); 'There was also a degree of empowerment that resulted from the group…' (Stanhope & Henwood, 2014); meaningful daily activities (incl. work and leisure activities; Paul et al., 2018; Illman et al., 2013); 'Being indoors is a lot, I mean you get to have more time with yourself.' (Stanhope & Henwood, 2014); '…drugs offered escape and relief.' (Muir-Cochrane et al., 2006); side effects of medications (Muir-Cochrane et al., 2006); fear of medication (Leipersberger, 2007); 'Being homeless made the most seemingly simple aspect of medication management a significant problem' (Muir-Cochrane et al., 2006); internal barriers (Stanhope & Henwood, 2014); postponement; minimization of symptoms; hiding symptoms (Stanhope & Henwood, 2014); '…the profound sense of being alone reinforced their helplessness about finding a way out of their predicaments.' (Zerger et al., 2014); perceiving a negative future as inevitable (Patterson et al., 2012); problem substance use as a barrier to successful coping with SMI and to reintegrating into society and to feeling 'normal' (Shibusawa & Padgett, 2009)	finding emotional releases; seeking refuges and sanctuaries; gaining an insight into difficulties and achieving (self)acceptance; maintaining ties with own (ethnic) community to help validate feelings related of illness and homelessness; finding an anchor; the value of informal supports; restoring one's dignity; connecting with peers/mentors; seeking respite. Barriers to coping; maladaptive coping; SU as a coping mechanism for blunting unwanted thoughts and emotions; SU interfering with the positive effects of psychiatric medications; Treatment adherence difficulties; self-harm; depletion of informal networks; internal barriers; lack of knowledge of available help and resources; negative self-image; pride; reluctance to disclose symptoms of mental illness; pessimism; social distancing; negative experiences with social services and care providers; distrust towards others, including medical professionals; feeling degraded and humiliated
'…definitely one of the big turning points because it simply allowed me to um, reevaluate things, you know, and just, and get my life together from there…Direction, just where was I heading… what was my purpose, you know…' (Shibusawa & Padgett, 2009); time for self-reflection (Shibusawa & Padgett, 2009); goal-setting (Paul et al., 2018); 'Participants' reminiscences were often infused with a sense of agency about making changes in their lives…' (Shibusawa & Padgett, 2009); 'Participants were keenly aware of the toll in death and illness that their homeless peers had suffered and suspected	***Reflection and meaning-making:*** The value of 'time out' and 'doing nothing time'; having space and time to evaluate; the lack of time for pausing and reflection; developing creativity and a new perspective on life; existential concerns; conceiving the desired life and the desired self; sense-making; expression of hope for the future and appreciation for life; importance of goal-setting; belief in one's potential for personal growth; nourishing one's gratitude and hope; accumulation of wisdom; the value of reflecting upon the past, adversity and one's younger self; grappling with regret and a sense of loss; restoring

their own life spans were going to be truncated.' (Shibusawa & Padgett, 2009); 'The women were able to make meaning of trauma by attributing the importance of the event in shaping who they were resulting in a sense of peace.' (Bonugli et al., 2013); 'That leads me to believe that there's a purpose for me ... In this life, you know? And God has allowed me to go through all this stuff…' (Bonugli et al., 2013); 'A total of 15 participants described drawing strength from 'having faith' in a higher power and were 'thankful' to this higher power for 'taking care' of them.' (Paul et al., 2018)	oneself in the world; spirituality and religiosity;
Regaining the lost trust and respect in children and family; (Paul et al., 2018); fostering positive social relationships (Gopikumar et al., 2015); maturation and wisdom; a sense of responsibility (Gopikumar et al., 2015); 'awareness of the future and 'time left' (Shibusawa & Padgett, 2009); '…congruence between the real and ideal self, and the drive to assume a more powerful identity and/or pursue self-actualisation' (Gopikumar et al., 2015); 'the striving for self-realisation, purpose and meaning of life' (Gopikumar et al., 2015); hope for the future; appreciation for life; self-responsibility; giving back to others; changing lives and reconnecting with others (including children); maturation; desire for a new life; the conviction that 'I have a lot more to grow on…'-; belief in one's higher purpose in life; opportunities to share knowledge and wisdom to help others; intrinsic volition as a desire for change; beginning to 'live', not just 'exist' (Bonugli et al., 2013); Being 'normal'; being 'human'; being 'happy'; belief that change is possible (Leipesberger, 2007); Hope and belief in one's own abilities; self-confidence; having goals (Paul et al., 2018)	***Personal reasons and motivations for coping:*** Connecting to self and to others; return to normality; achieving happiness; desire for change; belief in one's personal growth as a lifelong process; wisdom and maturation; self-realisation; achieving a positive self-identify; belief in the possibility of a better life; spiritual connectedness; self-confidence; a desire for autonomy

THE ASSEMBLAGE OF DISADVANTAGE (a higher-order construct):	
'… many participants described trajectories of accumulating risk and marginalization that contributed to their current experience of social devaluation, despair, and constrained choices.' (Patterson et al., 2012); 'Removal from the home environment, even though abusive, resulted in lost hope and feelings of alienation as reflected in the words of a participant…' (Bonugli et al., 2013); long-standing patterns of social withdrawal, loneliness, and lack of meaningful relationships (Bonugli et al., 2013); a breakdown of trust and security (Gopikumar et al., 2015); traumatic life events leading to SMI (Patterson et al., 2012); social and emotional 'uprootedness' (Bonugli et al., 2013); feelings of anger, shame, blame and guilt (Bonugli et al., 2013); apathy (Bonugli et al., 2013); emotional blunting and loss of touch with oneself (Bonugli et al., 2013); 'hardening' and diminished hope (Patterson et al., 2012)	***Context of early life. Emotional and psychological consequences of traumatic and other adverse life experiences:*** Multiple traumatic life experiences; marginalisation; victimisation; social disconnectedness; powerlessness and helplessness; chronic deprivation; lack of control and stability; emotional and psychological consequences of traumatic life experiences;
'Participants cited as useful relationships with service providers who "threw out the textbook" and offered care based on mutual communication, as well as those that provided advocacy when negotiating with other professionals…' (Voronka et al., 2014); unresponsive organizational policies; lack of compassion by staff (Leipersberger, 2007); high staff turnover hindering the continuity of care (Leipersberger, 2007); a sense of distrust towards health professionals (Stanhope & Henwood, 2014); financial resources frequently impeded access to medications (Muir-Cochrane et al., 2006); 'Participants reported that in such instances, it was difficult to convince some health professionals of the veracity of their story and so they were often denied a repeat prescription…' (Muir-Cochrane et al., 2006); '…many participants'	***Structural barriers to receiving effective health care and social supports:*** Biomedical model seen as unhelpful; compulsory treatment, rigidity and conditionality seen as unhelpful; difficulties accessing services; financial struggles; the fragmentation of services; bureaucratic barriers; unresponsive policies; lack of understanding from staff; importance of a sensitive and caring stance of the social workers; importance of a recovery- and social justice-oriented care; lack of privacy and security in the shelter system; the hospital environment as demoralising and demeaning; intersectional disadvantage-based on both mental health status, socio-economic status and housing arrangements

reflections point to structural factors operating beyond their control…' (Patterson et al., 2012); 'Within the shelters, the women often felt disrespected by shelter staff. (Bonugli et al., 2013)	
'These negative social attitudes further increase the alienation and marginalization of this population.' (Bonugli et al., 2013); 'The women in this study endure the three-fold stigma associated with mental illness, homelessness, and victimization.' (Bonugli et al., 2013); 'Aware of their status as a "homeless person," many participants reflected on how they were unfairly treated by public systems of care and by members of mainstream society…' (Patterson et al., 2012); 'A female living with a disability is often treated with scant respect and dignity.' (Gopikumar et al., 2015); 'Even when social distancing was not a direct result of stigma, and even when it was deemed necessary for recovery to progress, it had myriad negative effects which entrenched participants further into poverty and homelessness.' (Zerger et al., 2014); 'The powerful negative experience of stigma both caused and exacerbated feelings of not being 'normal,' and awareness of one's age sometimes heightened these feelings.' (Shibusawa & Padgett, 2009); 'When women refused services, they often did so publicly and on the grounds that they were not "crazy" (Luhrmann, 2008)	***Pervasive complex social stigma and its impact:*** Alienation and marginalisation caused by social attitudes; social and structural stigma towards the homeless; Intersectional stigma based on gender, mental illness and socio-economic status; mental health stigma in the family; negative staff attitudes; the detrimental effects of stigma-motivated social distancing; fear of being labelled as a barrier to formal help-seeking; race-based discrimination; identity struggles caused by stigma; self-stigma; feeling shame; homelessness as a cultural deviation; anticipated stigma

Table 2: Concept-context matrix: Prevalence of third-order concepts among the original studies

Study/Third-order construct	Survival strategies and adaptations to life on the streets	Coping with SMI and its impacts	Reflection and meaning-making	Personal reasons and motivations for coping	Context of early life	Structural barriers to receiving effective health care and public supports	Pervasive complex social stigma and its impact
Bonugli et al. (2013)	Yes	Yes	Yes	Yes	Yes	-	Yes
Gopikumar et al. (2015)	-	Yes	Yes	Yes	Yes	-	Yes
Illman et al. (2013)	Yes	Yes	-	-	-	-	-
Jensen (2017)	-	Yes	-	-	-	-	Yes
Leipersberger (2007)	-	Yes	-	Yes	-	Yes	Yes
Luhrmann (2008)	Yes	Yes	-	-	-	Yes	Yes
Muir-Cochrane et al. (2006)	-	Yes	-	-	-	Yes	-
Patterson et al. (2012)	-	Yes	-	-	Yes	Yes	Yes
Paul et al. (2018)	Yes	Yes	Yes	Yes	-	-	-
Shibusawa & Padgett (2009)	Yes	Yes	Yes	Yes	Yes	-	Yes
Stanhope & Henwood (2014)	Yes	Yes	-	-	-	Yes	Yes
Stolte & Hodgetts (2013)	Yes	Yes	-	-	-	-	-

Voronka et al. (2014)	-	Yes	-	-	-	Yes	Yes
Zerger et al. (2014)	Yes	Yes	-	Yes	-	-	Yes

Table 3: Design characteristics and methodological assessment scores of the included studies (N = 14)

Author(s), (Year), (Setting)	Research Question(s)	Sample Characteristics: • Sample size=N; • Age range and mean; • Gender ratio: % female; • Ethnicity breakdown; • Mental health status; • Housing circumstances	Study Design: • Design type; • Sampling method; • Data collection method(s); • Analytic method	RATS Score
Bonugli et al. (2013), (USA)	To understand the experiences of homeless women of SMI and victimisation; To describe the resources used to avoid victimisation	• N = 15; • 22-62 y.o.a; • 100% female; • 7 White, 6 African-American, 2 Hispanic; • A mix of schizoaffective disorder, MDD, bipolar disorder and SZ; • Residing in a homeless shelter.	• Qualitative description; • Purposive sampling; • Semi-structured interviews; • Content analysis	26/42
Gopikumar et al. (2015), (India)	To understand the causes for becoming and remaining homeless; To reveal approaches to support personal recovery in institutional settings	• N = 27 service users; N = 8 mental health professionals; • N/A; • 100% female (service-users); • 100% Indian; • N/A; • A mix of housing experiences and	• Mixed methods design; • Purposive sampling (maximum variation); • Focus groups, individual interviews, patient records;	25/42

		current circumstances	• Phenomenological analysis	
Illman et al. (2013), (Canada)	To understand occupational engagement in homeless persons living with mental illnesses	• N = 60; • Median: 44.5 y.o.a; Range: 20–64 y.o.a; • 33% female; • 24 White, 10 Asian, 15 Black, 11 Other; • N/A; • A mix of Housing First participants and TAU participants	• Mixed-method design; • Stratified random sampling from a larger sample; • In-depth interviews; questionnaire; • Constant comparative analysis	36/42
Jensen (2017), (USA)	'How does one nonprofit organization create a culture of dignity for their homeless and mentally-ill guests?'	• N = 6 workers; N = 4 volunteers; N = 5 guests; • N/A; • N/A; • N/A; • Residents of a hospitality house	• Ethnographic design; • Theoretical sampling; • Participant observation; field notes; semi-structured interviews; • Constructivist grounded theory	17/42
Leipersberger (2007), (USA)	To explore mental health consumers' perspectives of the mental health system	• N = 25; • Range: 22-54 y.o.a.; • 60% female; • 13 White, 12 African-American; • N/A • Residing in homeless shelters or supportive housing projects	• Qualitative design; grounded theory; • Purposive sampling; • Semi-structured interviews; field notes; • Constant comparative analysis	28/42
Lurhmann (2008), (USA)	To understand why persons experiencing both homelessness and mental illness often	• N = 61; • N/A; • 100% female; • N/A; • SZ, bipolar disorder,	• Ethnography; • N/A; • Semi-structured interviews; • N/A	19/42

	refuse help, especially formal help	and others; • Residing in homeless shelters; supportive accommodation; and street homeless		
Muir-Cochrane et al. (2006), (Australia)	To understand the experiences of homeless young people with a history of mental health problems of managing medications.	• N = 10; • Range: 16-24 y.o.a.; • 50% female; • N/A; • N/A; • Residing in temporary housing	• Qualitative design; • N/A • In-depth interviews; • Thematic analysis; interpretative phenomenology	25/42
Patterson et al. (2012), (Canada)	To explore experiences of inequity in homeless persons with mental disorders	• N = 31; • Range: 26-66 y.o.a; Mean: 45 y.o.a; • 35% female; • 18 White, 2 Black, 8 Aboriginal, 3 Mixed; • Psychotic disorder, MDD, PTSD and others; • 25 absolutely homeless, 6 precariously housed	• Qualitative design; • Purposive sampling; • Semi-structured narrative interviews; personal timelines; • Thematic analysis	28/42
Paul et al. (2018), (Canada)	To study '…the personal perceived strengths, attitudes and coping behaviors of homeless adults of diverse ethnoracial backgrounds experiencing homelessness and mental illness in Toronto, Canada'	• N = 36; • Mean= 37 y.o.a. (SD=11.3); • 22% female; • 8 Black African, 8 Black Canadian, 6 Black Caribbean of mixed ethnicity, 4 Middle Eastern, 3 South Asian; 1 Latin American; • Depression, psychosis, PTSD; • Housing First and Treatment as Usual homeless persons	• Qualitative design; • Purposive and stratified sampling; • Semi-structured interviews; • Thematic analysis	29/42
Shibusawa &	To study the lived	• N = 25;	• Qualitative	30/42

Padgett (2009), (USA)	experiences and key life events of being homeless and having a serious mental illness and/or substance use problems	• Mean: 53 y.o.a (SD=5.81); • 40% female; • 13 White, 9 African-American, 2 Latino/a, 1 Other; • Schizophrenia, bipolar, major depression, psychosis; • 15 supported housing; 2 shelters; 2 independent housing; 3 single-room occupancy apartments; 2 long-term transitional housing	design; • Purposive sampling (maximum variation); • Semi-structured interviews; • Thematic analysis; case study analysis	
Stanhope & Henwood (2014), (USA)	To understand consumer perspectives on the major barriers and facilitators to addressing their health and social needs presented by concurrent homelessness and SMI	• N = 15; • N/A; • 100% male; • N/A • N/A; • Housing First participants	□ Qualitative, community-based participatory design; • N/A □ individual semi-structured interviews; □ Thematic analysis	26/42
Stolte & Hodgetts (2015), (New Zealand)	To explore the ways in which a homeless man maintains his health.	• N = 1; • 47 y.o.a; • 100% male; • N/A; • Depression; • Street homeless	• Ethnographic case study; • N/A • A biographical interview, photo-elicitation project, photograph-based interview, health interview and various go-along conversations and direct observations;	14/42

			• N/A	
Voronka et al. (2014), (Canada)	To understand participants' experiences of health and social services provision.	• N = 30; • N/A • 33% female; • 16 White, 8 non-White, 6 Aboriginal; • N/A; • At Home/Chez Soi and Treatment as Usual homeless participants	• Qualitative design; • Stratified and purposeful sampling • Narrative interviews; • Peer-led data analysis	19/42
Zerger et al. (2014), (Canada)	To explore '…how individuals who bear these multiple identities of oppression navigate stigma and discrimination, and what affects their capacity to do so'	• N = 36; • N/A; • 25% female; • 24 Canada-born; 12 foreign-born; • Psychotic disorder and others; • Absolutely homeless or precariously housed	• Mixed-method study; • Purposive and stratified sampling; • In-depth interviews; • Grounded-theory informed analysis	33/42

Table 4: Assessment of the confidence in the findings from the current metasynthesis using the GRADE-CERQual method (Lewin et al., 2015)

GRADE CERQual Component: Self-Assessment	**Outcome of the Self-Assessment**
Methodological limitations: A systematic quality appraisal was conducted and studies of low methodological rigour was excluded. Yet, the majority of included studies were of medium rigour. Some common methodological caveats of the original studies are worth noting: thin description of themes; minimal or no engagement with theory; lack of information on rigour assurance and respondent validation; inadequate detail of the data analysis process.	Moderate concerns
Relevance: Based on the inclusion criteria, only studies whose entire samples	Minor concerns

were persons with a history of an SMI and who were homeless at the time of the study (unless they narrated about their experience of being homeless) were considered. The assessment of conceptual clarity ensured that only studies that were highly relevant to the review question were included.	
Coherence: The line-of-argument synthesis derived demonstrates the high degree of coherence among the third-order constructs. Few significant 'untranslated' concepts remained. The results represent a mix of descriptive and interpretive findings.	Minor concerns
Adequacy of data: Despite the comprehensive search strategy, only 14 studies met the inclusion criteria after quality assessment. Two of the third-order concepts were supported by only four (29%) of the original studies.	Moderate concerns
Overall assessment: **Moderate confidence**: It is likely that the findings from the metasynthesis are a reasonable representation of the phenomenon of coping with SMI in the context of homelessness.	

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Monday, August 9, 2021 12:21 PM
To: Works-Wright, Jamie
Cc: Klatt, Karen
Subject: FW: Draft MHSA Innovations Homeless Encampment Wellness Project Discussion at MHSA Advisory Committee Meeting

Hello Commissioners,

Please see the email below from Karen Klatt about the **Draft Homeless Encampment Wellness Project will be discussed during the MHSA Advisory Committee meeting this month, which will be held on Tuesday, August 17th from 11-12:30pm.**

Please let me know by Friday, August 13th whether you will be attending the meeting, I will send the meeting invite out to you on Monday, August 16th.

Jamie Works-Wright
Consumer Liaison
Jworks-wright@cityofberkeley.info
510-423-8365 cl
510-981-7721 office

From: Klatt, Karen
Sent: Monday, August 9, 2021 9:57 AM
To: Works-Wright, Jamie <JWorks-Wright@cityofberkeley.info>
Subject: Draft MHSA Innovations Homeless Encampment Wellness Project Discussion at MHSA Advisory Committee Meeting

Hi Jamie,

Could you please send this email to the MH Commission?

Thanks much!

Karen

Greetings MH Commissioners,

I wanted to inform you that in addition to being an agenda item for discussion at the September MH Commission meeting, the Draft Homeless Encampment Wellness Project will be discussed during the MHSA Advisory Committee meeting this month, which will be held on Tuesday, August 17th from 11-12:30pm. The discussion will begin around 11:20am during the meeting.

MH Commissioners are welcome to attend, you will just need to be mindful of not reaching a quorum at the meeting. ***If you could let Jamie know by Friday, August 13th whether you will be attending the meeting, she will send the meeting invite out to you on Monday, August 16th***.

Thanks much,

Karen

Karen Klatt, MEd
MHSA Coordinator
City of Berkeley, Mental Health Division
3282 Adeline Street, Berkeley CA 94703
(510) 981-7644 – Office
(510) 849-7541 – Cell
KKlatt@cityofberkeley.info

From: Klatt, Karen
Sent: Monday, August 2, 2021 10:09 AM
To: Works-Wright, Jamie <JWorks-Wright@cityofberkeley.info>
Subject: Draft MHSA Innovations Homeless Encampment Wellness Project

Hi Jamie,

Can you please forward this email to the MH Commission?

Dear MH Commissioners,

Thank you all for the very valuable input you provided at the Public Hearing for the MHSA FY22 Annual Update. The Division will be using the input to inform future MHSA Three Year Plans and Updates. Additionally, I will be utilizing the input received to modify and strengthen the Annual MHSA Planning and Community Input process and hope to partner with you on any additional input and strategies you may suggest.

Attached you will find the Draft MHSA Innovations Homeless Encampment Wellness Project and the Report on the Community Planning Process that was conducted for this draft project. There were several questions and comments regarding this project at the Public Hearing and as such per an email from Margaret, an agenda item for this project will be added for the September Mental Health Commission Meeting. Either the consultant who conducted this process or I will be available to address this agenda item at the September

meeting. Regarding the community planning process, in addition to the community input received from the general public during the Town Hall and through the Berkeley Considers Survey, input from the Survey and interviews of individuals who are experiencing homelessness, the survey of Berkeley Mental Health staff, and the meetings with individuals who are homeless advocates, the Division also vetted this draft project through the City Manager's office and received enthusiastic support on it.

As I mentioned during the Public Hearing, Innovations funding requires several additional steps more than the MHSA Three Year Plans and Updates to obtain approval on a draft plan. The steps are as follows:
-Conducting local community outreach to obtain input on local needs and strategies to address needs;
-Creating a Draft Plan;
-Working with staff at the State Mental Health Oversight and Accountability Commission (MHSOAC) to ensure a plan is fundable under MHSA Innovations requirements, and adjusting the Draft plan accordingly;
-Conducting a 30-Day Public Review to obtain local input on the Draft Plan;
-Conducting a Public Hearing on the Draft Plan at a Mental Health Commission Meeting where the Mental Health Commission will also vote on the plan;
-Obtaining approval from City Council; and
-Obtaining approval from the MHSOAC.

The step we are currently on with this plan is working with the staff at the MHSOAC on any changes needed, prior to the plan going out for local feedback. Therefore, there are still opportunities for Commissioners and the Community to provide input into this Draft Plan.

Thanks,

Karen

Karen Klatt, MEd

MHSA Coordinator

City of Berkeley, Mental Health Division

3282 Adeline Street, Berkeley CA 94703

(510) 981-7644 – Office

(510) 849-7541 – Cell

KKlatt@cityofberkeley.info

Works-Wright, Jamie

From:	Works-Wright, Jamie
Sent:	Monday, August 2, 2021 1:58 PM
To:	Works-Wright, Jamie
Subject:	FW: Draft MHSA Innovations Homeless Encampment Wellness Project
Attachments:	DRAFT MHSA INN Homeless Encampment Wellness Project.docx; MHSA INN Community Planning Report.pdf

Hello Commissioners,

Please see the email below from Karen Klatt, MHSA Coordinator

Thank you for your time.

Jamie Works-Wright
Consumer Liaison & Mental Health Commission Secretary
City of Berkeley
1521 University
Berkeley, CA 94703
Jworks-wright@cityofberkeley.info
Office: 510-981-7721 ext. 7721
Cell #: 510-423-8365

From: Klatt, Karen
Sent: Monday, August 2, 2021 10:09 AM
To: Works-Wright, Jamie <JWorks-Wright@cityofberkeley.info>
Subject: Draft MHSA Innovations Homeless Encampment Wellness Project

Hi Jamie,

Can you please forward this email to the MH Commission?

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Thanks,

Karen

Karen Klatt, MEd

MHSA Coordinator

City of Berkeley, Mental Health Division

3282 Adeline Street, Berkeley CA 94703

(510) 981-7644 – Office

(510) 849-7541 – Cell

KKlatt@cityofberkeley.info

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Wednesday, July 28, 2021 3:08 PM
To: Works-Wright, Jamie
Cc: Grolnic-McClurg, Steven; Klatt, Karen
Subject: FW: Division of Mental Health programs, services, funding and Next Mental Health Commission meeting

Please see the message below from Margaret Fine

Thank you for your time.

Jamie Works-Wright
Consumer Liaison & Mental Health Commission Secretary
City of Berkeley
1521 University
Berkeley, CA 94703
Jworks-wright@cityofberkeley.info
Office: 510-981-7721 ext. 7721
Cell #: 510-423-8365

From: Margaret Fine <margaretcarolfine@gmail.com>
Sent: Wednesday, July 28, 2021 12:04 PM
To: Works-Wright, Jamie <JWorks-Wright@cityofberkeley.info>
Subject: Fwd: Division of Mental Health programs, services, funding and Next Mental Health Commission meeting

Hi Jamie,

I just want to touch base and see if you would kindly forward this email to the Mental Health Commissioners and copy it to the Mental Health Division Manager and the MHSA Coordinator? Please let me know if there are any questions or concerns. It is much appreciated. Thank you so much!

Dear Commissioners,

I would like to ask about the next presentation for the Mental Health Commission meeting in September, 2021.

Based on the number of questions raised at the last meeting, it seems that there is keen interest in the scope and nature of programs and services of the public mental health system for the City of Berkeley (the Division of Mental Health), and the spending priorities and use of funds by the Division of Mental Health.

One suggestion is inviting frontline and supervisory staff to the Mental Health Commission meeting to explain and answer questions about the scope and nature of the Division's programs and services (such as for children, youth and families (CYF); transition age youth, adults, and older adults; and for individuals experiencing homelessness). These programs and services represent a major portion of the Division of Mental Health's budget. We have had this presentation and question/answer period in the past and it was very informative. Please let us know your interest or alternative suggestions.

In addition there will be an agenda item on the MHSA INN Homeless Wellness Project so Commissioners can make inquiries into the nature of this proposed program at our public meeting.

Please also feel free to send an email with further information for addressing these topics. I would also note that most funding received by the Division of Mental Health is restricted funding and there are very specific parameters and criteria that must be followed for program and service delivery by the Division.

Thanks so much. We look forward to hearing from you.

Best wishes,
Margaret

Margaret Fine
Chair, Mental Health Commission
Cell: 510-919-4309

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Wednesday, July 28, 2021 11:03 AM
To: Works-Wright, Jamie
Subject: FW: Reimagining Public Safety Task Force Meeting - 6 pm, Thursday, July 29 & Agenda Packet
Attachments: Reimagining-Public-Safety-Task-Force 7-29 Meeting Packet.pdf

Please see the information from Margaret, MHC Chair

Thank you for your time.

Jamie Works-Wright
Consumer Liaison & Mental Health Commission Secretary
City of Berkeley
1521 University
Berkeley, CA 94703
Jworks-wright@cityofberkeley.info
Office: 510-981-7721 ext. 7721
Cell #: 510-423-8365

From: Margaret Fine <margaretcarolfine@gmail.com>
Sent: Tuesday, July 27, 2021 10:56 PM
To: Works-Wright, Jamie <JWorks-Wright@cityofberkeley.info>
Subject: Reimagining Public Safety Task Force Meeting - 6 pm, Thursday, July 29 & Agenda Packet

Hi Jamie,

Would you please kindly send this email to the Commissioners? Thank you so much. It is sincerely appreciated.

Dear Commissioners,

As some Commissioners know, there is a Reimagining Public Safety Task Force meeting on Thursday, July 29, at 6 pm. The agenda packet is posted and can be found at the following link: https://www.cityofberkeley.info/RIPST.aspx.

The upcoming public meeting will include discussion on the following items contained in the agenda packet (also attached).

- Reimagining Public Safety Task Force Status and Next Steps
- Community Engagement Report and Update - please note that the listening session summaries and findings are contained in this report.
- Alternative Responses Draft Report - please note that this report discusses the SCU.

***Please note:* Appendix D of the Alternative Responses Draft Report is forthcoming and will be shared as soon as it's available.

https://www.cityofberkeley.info/uploadedFiles/Clerk/Level_3_-_Commissions/Reimagining-Public-Safety-Task-Force%207-29%20Meeting%20Packet.pdf

Reimagining Public Safety Task Force

REIMAGINING PUBLIC SAFETY TASK FORCE MEETING

Thursday, July 29, 2021
6:00 PM

District 1 - Margaret Fine	Youth Commission - Vacant
District 2 - Sarah Abigail Ejigu	Police Review Commission - Nathan Mizell
District 3 - boona cheema	Mental Health Commission - Edward Opton
District 4 - Paul Kealoha Blake	Berkeley Community Safety Coalition - Vacant
District 5 - Dan Lindheim	Associated Students of U. California - Alecia Harger
District 6 - La Dell Dangerfield	At-Large - Alex Diaz
District 7 - Barnali Ghosh	At-Large - Liza Lutzker
District 8 - Pamela Hyde	At-Large - Frances Ho
Mayor - Hector Malvido	

PUBLIC ADVISORY: THIS MEETING WILL BE CONDUCTED EXCLUSIVELY THROUGH VIDEOCONFERENCE AND TELECONFERENCE

Pursuant to Section 3 of Executive Order N-29-20, issued by Governor Newsom on March 17, 2020, this meeting of the Reimagining Public Safety Task Force will be conducted exclusively through teleconference and Zoom videoconference. Please be advised that pursuant to the Executive Order, and to ensure the health and safety of the public by limiting human contact that could spread the COVID-19 virus, there will not be a physical meeting location available.

To access the meeting remotely using the internet: Join from a PC, Mac, iPad, iPhone, or Android device: Use URL https://us02web.zoom.us/j/84701596327. If you do not wish for your name to appear on the screen, then use the drop down menu and click on "rename" to rename yourself to be anonymous. To request to speak, use the "raise hand" icon on the screen.

To join by phone: Dial **(669) 900 9128** and Enter Meeting ID: **847 0159 6327.** If you wish to comment during the public comment portion of the agenda, press *9 and wait to be recognized by the Chair.

Please be mindful that all other rules of procedure and decorum will apply for Commission meetings conducted by teleconference or videoconference.

AGENDA

Preliminary Matters

1. Roll Call

2. Public Comment *(speakers will be limited to two minutes)*

3. Approval of Minutes
Draft minutes for the Commission's consideration and approval

- Meeting of July 8, 2021

Discussion/Action Items

The public may comment on each item listed on the agenda. Public comments are limited to two minutes per speaker.

- Reimagining Public Safety Task Force Status and Overview – Chair Mizell
- Community Engagement Update – National Institute for Criminal Justice Reform
    - Community Engagement Survey Draft Report
    - Initial Community Listening Sessions Results and Draft Report
- Alternative Responses Draft Report – National Institute for Criminal Justice Reform
- Reimagining Public Safety Task Force Next Steps and Reflection – Chair Mizell
    - NICJR Contract Update - National Institute for Criminal Justice Reform

Subcommittee Reports

Each report should be limited to 15 minutes.

- Policing, Budget & Alternatives to Policing – Members Opton, Ghosh, cheema, Dangerfield, Lindheim, Mizell, Harger, Hyde
- Community Engagement – Members Fine, Harger, Malvido, Lutzker, Ejigu, Blake
- Improve and Reinvest – Members Ho, Lutzker, cheema, Fine, Malvido, Diaz
- Alternative Solutions to Gender Based Violence - Members Ghosh, cheema, Ho

Subcommittee Discussion

Items for Future Agenda

Adjournment

This meeting will be conducted in accordance with the Brown Act, Government Code Section 54953. Any member of the public may attend this meeting. Questions regarding this matter may be addressed to Mark Numainville, City Clerk, (510) 981-6900.

Any writings or documents provided to a majority of the Reimagining Public Safety Task Force regarding any item on this agenda are on file and available upon request by contacting the City Manager's Office attn: Reimagining Public Safety Task Force at rpstf@cityofberkeley.info, or may be viewed on the City of Berkeley website: http://www.cityofberkeley.info/commissions.

Written communications addressed to the Reimagining Public Safety Task Force and submitted to the City Manager's Office by 5:00 p.m. the Friday before the meeting will be distributed to members of the Task Force in advance of the meeting. Communications to the Reimagining Public Safety Task Force are public record and will become part of the City's electronic records, which are accessible through the City's website. Please note: e-mail addresses, names, addresses, and other contact information are not required, but if included in any communication to the Reimagining Public Safety Task Force, will become part of the public record. If you do not want your e-mail address or any other contact information to be made public, you may deliver communications via U.S. Postal Service to the secretary of the task force. If you do not want your contact information included in the public record, please do not include that information in your communication. Please contact the secretary for further information.

****

COMMUNICATION ACCESS INFORMATION:
To request a disability-related accommodation(s) to participate in the meeting, including auxiliary aids or services, please contact the Disability Services Specialist at (510) 981-6418 (V) or (510) 981-6347(TDD) at least three business days before the meeting date.

Reimagining Public Safety Task Force Contact Information:
David White and Shamika Cole
Co-Secretaries, Reimagining Public Safety Task Force
City of Berkeley
2180 Milvia Street, 5th Floor
Berkeley, CA 94704
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Reimagining Public Safety Task Force

REIMAGINING PUBLIC SAFETY TASK FORCE
Draft Meeting Minutes

Thursday, July 8, 2021
6:00 PM

District 1 - Margaret Fine	Youth Commission - Vacant
District 2 - Sarah Abigail Ejigu	Police Review Commission - Nathan Mizell
District 3 - boona cheema	Mental Health Commission - Edward Opton
District 4 - Paul Kealoha Blake	Berkeley Community Safety Coalition - Vacant
District 5 - Dan Lindheim	Associated Students of U. California - Alecia Harger
District 6 - La Dell Dangerfield	At-Large - Alex Diaz
District 7 - Barnali Ghosh	At-Large - Liza Lutzker
District 8 - Pamela Hyde	At-Large - Frances Ho
Mayor - Hector Malvido	

PUBLIC ADVISORY: THIS MEETING WILL BE CONDUCTED EXCLUSIVELY THROUGH VIDEOCONFERENCE AND TELECONFERENCE

Pursuant to Section 3 of Executive Order N-29-20, issued by Governor Newsom on March 17, 2020, this meeting of the Reimagining Public Safety Task Force will be conducted exclusively through teleconference and Zoom videoconference. Please be advised that pursuant to the Executive Order, and to ensure the health and safety of the public by limiting human contact that could spread the COVID-19 virus, there will not be a physical meeting location available.

To access the meeting remotely using the internet: Join from a PC, Mac, iPad, iPhone, or Android device: Use URL https://us02web.zoom.us/j/81983354907. If you do not wish for your name to appear on the screen, then use the drop down menu and click on "rename" to rename yourself to be anonymous. To request to speak, use the "raise hand" icon on the screen.

To join by phone: Dial **(669) 900 9128** and Enter Meeting ID: **819 8335 4907.** If you wish to comment during the public comment portion of the agenda, press *9 and wait to be recognized by the Chair.

Please be mindful that all other rules of procedure and decorum will apply for Commission meetings conducted by teleconference or videoconference.

Roll Call: **6:02 p.m.**

Present: Fine, cheema, Ejigu, Blake, Lindheim, Dangerfield, Ghosh, Hyde, Mizell, Opton, Harger, Diaz, Lutzker

Absent: Malvido, Ho

Public Comment on Non-Agenda Matters: 1 speaker

Minutes for Approval
Draft minutes for the Commission's consideration and approval.

Action: M/S/C (Mizell/Harger) to approve the minutes of 6/30/21. Vote: Ayes – Fine, Ejigu, cheema, Blake, Lindheim, Dangerfield, Ghosh, Hyde, Mizell, Opton, Harger, Diaz, Mizell, Noes – None; Absent – Malvido, Ho

Commission Action Items

Action: M/S/C (Mizell/Blake) to reorder the agenda; SCU discussion to occur prior to Police presentation. Vote: Ayes – Fine, Ejigu, cheema, Blake, Lindheim, Dangerfield, Ghosh, Hyde, Mizell, Opton, Harger, Diaz, Mizell, Noes – None; Absent – Malvido, Ho

Public Comment on Agenda/Discussion Matters: 2 speakers

Items for Future Agenda

- Presentations from community-based organizations

Adjournment

Action: M/S/C (Mizell/cheema) to adjourn the meeting.

Vote: Ayes – Fine, Ejigu, cheema, Blake, Lindheim, Dangerfield, Ghosh, Hyde, Mizell, Opton, Harger, Diaz, Mizell, Noes – None; Absent – Malvido, Ho

Adjourned at 9:34 p.m.

Next Meeting – July 29, 2021.

I hereby certify that the foregoing is a true and correct record of the Reimagining Public Safety Task Force meeting held on July 8, 2021.

Respectfully Submitted,

_____

David White – Commission Co-Secretary
Shamika Cole – Commission Co-Secretary

Communications
Communications submitted to the Reimagining Public Safety Task Force are on file in the City Manager's Office at 2180 Milvia Street, 5th Floor, Berkeley, CA and are available upon request by contacting the City Manager's Office at (510) 981-7000 or rpstf@cityofberkeley.info.

Public Safety Reimagining Task Force
Roles and Responsibilities
April 1, 2021

Reimagining Public Safety Objective

Develop a new paradigm of public safety that should include, but is not limited to:

1. Building on the work of the City Council, the City Manager, Berkeley Police Department, the Police Review Commission and other City commissions and other working groups addressing community health and safety.

2. Research and engagement to define a holistic, anti-racist approach to community safety, including a review and analysis of emerging models, programs and practices that could be applied in Berkeley.

3. Recommend a new, community-centered safety paradigm as a foundation for deep and lasting change, grounded in the principles of Reduce, Improve and Reinvest as proposed by the National Institute for Criminal Justice Reform (NICJR) considering, among other things:

    a. The social determinants of health and changes required to deliver a holistic approach to community-centered safety.
    b. The appropriate response to community calls for help including size, scope of operation and power and duties of a well-trained police force.
    c. Limiting militarized weaponry and equipment.
    d. Identifying alternatives to policing and enforcement to reduce conflict, harm, and institutionalization, introduce alternative and restorative justice models, and reduce or eliminate use of fines and incarceration.
    e. Options to reduce police contacts, stops, arrests, tickets, fines and incarceration and replace these, to the greatest extent possible, with educational, community serving, restorative and other positive programs, policies and systems.
    f. Reducing the Berkeley Police Department budget to reflect its revised mandates, with a goal of a 50% reduction, based on the results of requested analysis and achieved through programs such as the Specialized Care Unit.

Role of National Institute for Criminal Justice Reform (NICJR)

1. Working with the City Auditor on the assessment of emergency and non-emergency calls for service.

2. Developing a summary and presentation of new and emerging models of community safety and policing.

3. Developing and implementing a communications strategy to ensure that the community is well informed, a robust community engagement process, and managing the Task Force established by the City Council.

4. Identifying the programs and/or services that are currently provided by the Berkeley Police Department that can be provided by other City departments and / or organizations.

5. Developing a final report and implementation plan that will be used to guide future decision making

Task Force Roles and Responsibilities

As the Reimagining Public Safety process unfolds and comes to life, the Task Force will be relied upon to provide input, participate in the process, and to help shape recommendations that can be implemented over time for a new model of public safety.

Per the Enabling Legislation, the Task Force is responsible for the following:

1. Provide input to and make recommendations to NICJR and City Staff on a set of recommended programs, structures and initiatives incorporated into a final report and implementation plan developed by NICJR to guide future decision making in upcoming budget processes for FY 2022-23 and, as a second phase produced, in the FY 2024-2025 budget processes.

2. In lieu of subcommittees and advisory boards, look to City commissions and community organizations to provide additional input and research to inform the Task Force's work rather than establish additional community advisory boards.

The City Manager is requested to provide updates and coordinate with the Task Force regarding the work that is underway on various aspects of the July 14, 2020 Omnibus package adopted by City Council including the following:

- Specialized Care Unit;
- BerkDoT; and
- Priority dispatching.

The following is an illustrative list of questions for the Task Force as we embark on this journey. Rather than being all encompassing, these list of questions are meant to be a starting point for future meetings and discussion.

1. In reviewing the proposed schedule of meetings and topics, what gaps does the Task Force perceive? Are there other departments, community groups, individuals that the Task Force would like to hear from or engage with? Who on the Task Force can help arrange these connections and discussions?

2. After reviewing and discussing the community engagement process, what recommendations does the Task Force have to strengthen the process and in what ways can the Task Force support the process?

3. How can the Task Force assist in ensuring a robust response to the community survey administered by NICJR?

4. Calls for Service Analysis. The City Auditor will present an overview and categorization of calls for service to the Task Force and NICJR will offer a framework to evaluate calls for service. What calls should the Berkeley Police Department respond to? What other partners and / or City departments can be relied upon to respond to calls for service? What impacts will this have on the Berkeley Police Department?

5. With respect to the new models of community safety outlined by NICJR, what models make sense for Berkeley? Are there any specific initiatives or programs that the Task Force would like NICJR to look further into? Are there any items that the Task Force would like to explore?

6. NICJR will bring forward to the Task Force programs and/or services that are currently provided by the Berkeley Police Department that can be provided by other City departments and / or organizations. Does the Task Force agree that these are programs or services that can be provided outside of the Police Department? Are there other programs and services that the Task Force would like NICJR to look into? If yes, what are they?

7. In considering the results of NICJR's community engagement efforts and any other community engagement performed by the Task Force or any other City entity (i.e., RDA for the Specialized Care Unit), what does this mean in terms of community services that should be available for the community?

8. With respect to the recommended approach to public safety, for the Berkeley Police Department what impacts does this have:

    a. Services offered
    b. Size
    c. Allocated resources

    What impacts does the recommended approach to public safety have on other Departments in the City? Other organizations?

    Is the implementation plan outlined by NICJR achievable? Will it produce desired outcomes? Does the implementation plan reflect all of the items adopted by City Council including Specialized Care Unit, BerkDoT, and priority dispatching?

    How can the City measure progress in implementing recommendations advanced by NICJR and the Task Force?

Public Safety Reimagining Task Force
Proposed Meeting Schedule
Revised as of July 21, 2021

1. April 8, 2021 (Regular Meeting)
   - Task Force Meeting Schedule and Role (City)
   - Draft Community Survey (Bright Research Group)
   - Police Department Overview #1 (Interim Chief Louis)
   - Priority Dispatch Overview (Fire Chief Brannigan)
   - Special Task Force Meeting Dates (April 29, 2021, May 19, 2021 and June 30, 2021)
   - Subcommittee Discussion

2. April 29, 2021 (Special Meeting)
   - Calls for Service Analysis – City Auditor
   - Calls for Service Analysis Framework -- NICJR
   - New and Emerging Models of Community Safety (NICJR and team)

3. May 13, 2021 (Regular Meeting)
   - Police Department Overview #2 (Topic: Recruitment and hiring process, entry level training, Crisis Intervention Training and Fair and Impartial Policing related training) (Interim Chief Louis)
   - Specialized Care Unit

4. May 19, 2021 (Special Meeting)
   - Fair and Impartial Workgroup Recommendations and Police Dept. Implementation (Fair and Impartial Workgroup and Interim Chief Louis)
   - BerkDOT (L. Garland and F. Javandel)

5. June 10, 2021 (Regular Meeting)
   - Police Department Presentation #3 (Budget overview and detail around staffing level/beat coverage as well as expanding on calls-for-service data audit)
   - Submit Final New and Emerging Models Report to Task Force (NICJR)

6. June 30, 2021 (Special Meeting)
   - Police Department Presentation #4 (processes and procedures for evaluation, training, commendation, discipline including Internal Affairs and partnership with Police Review Commission/Police Accountability Board)

7. July 8, 2021 (Regular Meeting)
   - Police Department Presentation #5
     - Community engagement and City/Community partnerships
     - Focused discussions on the duties and responsibilities of non-patrol beat units to include detectives, traffic, community services, bike team, personnel and training, support services. Overview of the work BPD is currently responsible for outside of responding to initial calls for service and proactive crime prevention efforts
   - Specialized Care Unit Update #2 (L. Warhuus)

8. Tentative for Discussion -- Special Meeting in July – TBD (Maybe July 29, 2021, it's a 5th Thursday, likely no other commission meetings)
   - Draft Alternatives Responses Report (NICJR)
   - Draft Community Survey Results Report and Draft Initial Community Listening Session Results Report (NICJR)

9. August 12, 2021
   - Cancel due to recess

10. September 9, 2021 (may need reschedule, this is the recess period)
    - Tentative -- Draft Final Report Presentation (NICJR)

11. October 14, 2021 (may need reschedule, this is the recess period)
    - Tentative -- Task Force Approve and Accept Final Report Presentation (NICJR)

Unscheduled Meetings / Presentations

- Presentation Regarding Police Accountability Board
- Professor Jordan Blain Woods (Prof. Woods is a criminologist and legal scholar who has published extensively on traffic and policing, both in law review articles and in the popular press.)

COMMUNITY ENGAGEMENT REPORT

NICJR
National Institute for
Criminal Justice Reform

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NICJR
National Institute for
Criminal Justice Reform

Berkeley Reimagining Public Safety
Community Engagement Report

Overview:

The Reimagining Public Safety process in Berkeley includes comprehensive outreach and engagement of local community members. The National Institute for Criminal Justice Reform (NICJR) and our partners Brightstar Research Group (BRG), with significant support and input from the Reimagining Public Safety Taskforce, developed a multi-pronged community engagement strategy. The process included a broadly distributed survey along with a series of listening sessions designed to engage marginalized, hard to reach, or communities with high rates of police contact. With guidance from the City Manager's Office, BRG focuses on four populations for listening sessions: Black, Latinx, formerly incarcerated and low-income individuals struggling with food and/or housing insecurity. The following report includes initial findings from these events and the survey.

Community Engagement efforts are continuing with additional information to be submitted from the two Latinx listening sessions organized by Taskforce member Hector Malvido as well as those planned by the Gender-Equity and Violence Subcommittee. The Taskforce is also working with the Pacific Center on Human Growth to organize interviews with service providers and participants in their LGBTQIA+ programs. Information and perspectives garnered from this wide array of community engagement will help to inform NICJR's final report and provide valuable information for the work of the Taskforce and the City of Berkeley moving forward.

Berkeley Reimagining Public Safety Process
Community Engagement Timeline

Community Engagement Event	Lead Entity	Date	Attendance	Status of Summary Data
BPD focus group with command staff	NICJR	May 6, 2021		Pending
Community Survey	BRG	May 14, 2021	2,729	In report
Listening Session/Community meeting – focus on Black community	BRG-Pastor Smith	May 25, 2021	18	In report
BPD focus group with line staff	NICJR	June 2, 2021 & June 3, 2021		Pending
Berkeley Merchant Association Focus group	NICJR - In coordination with Telegraph BA and Downtown BA	June 2, 2021	6	In report
Listening Session/Community meeting – Housing Unstable and Formerly Incarcerated (focus on POC)	BRG-Center for Faith Food and Justice	June 9	27	In report
Vulnerable Youth Listening Session (ages 13-17)	BRG-Pastor Smith	June 28th	4	In report
Listening Session for residents experiencing mental health challenges	NICJR - In coordination with CE TF Commissioner Fine	June 29, 2021	14	In report
BIPOC students Listening Session	BRG-Underground Scholars	June 30th	4	In report
LGBTQ/Trans Community Listening Session	NICJR - In coordination with CE	July 1, 2021	0	No data

	TF Commissioner Fine			
Latinx Listening Session	TF Commissioner Malvido-with support from NICJR	July 8, 2021		Pending
Latinx Listening Session Youth from Berkeley High School	TF Commissioner Malvido-with support from NICJR	TBD (Before 7/16)		Pending
Gender-Equity and Violence	Gender-Equity and Violence Subcommittee	TBD (Before 7/16)		Pending
Gender-Equity and Violence	Gender-Equity and Violence Subcommittee	TBD (Before 7/16)		Pending
Citywide Town Hall	NICJR/Task Force CE Subcommittee/City Mgr's office	After Alternative Responses Draft has been shared		Pending
District 1-9 specific meetings	NICJR	After Final Report drafted		Pending
Develop Report on process and findings from Community Engagement/Outreach and Community Survey results	BRG	July 6		Pending

Purpose of Sessions:
Get input on each group's opinions, ideas, concerns, on public safety in Berkeley, police reform, and needed community services/resources. Also get specific responses to proposed reforms like community based alternative responses to Calls for Services and BerkDOT. All of this feedback will be compiled into a report for the Taskforce and City Council as well as used to inform the drafting and updating of reports developed by NICJR for the Reimagining Public Safety process.

BRIGHT RESEARCH GROUP

City of Berkeley Reimagining Public Safety Survey— Summary Report

Moira DeNike, PhD., and Alice Hu-Nguyen, MSPH
Bright Research Group | July 1, 2021

INTRODUCTION

The City of Berkeley is developing a community safety model that reflects the needs of the community and creates increased safety for all. In collaboration with the City of Berkeley's Reimagining Public Safety Task Force and the City Manager's Office, Bright Research Group (BRG) developed and conducted a community survey to gather residents' experiences with and perceptions of the Berkeley Police Department and crisis response; their perspectives on and priorities for reimagining public safety; and recommendations for alternative responses for community safety. This report summarizes the key quantitative findings from the City of Berkeley's Reimagining Public Safety Survey.

METHODS AND SAMPLE

A total of 2,729 responses were collected between May 18 and June 15, 2021. The City of Berkeley, the Reimagining Public Safety Task Force, community-based organizations, and other key partners disseminated the community survey through various online channels and websites to those who live, work, and study in Berkeley, in English and Spanish. Respondents completed the survey online.

Descriptive and statistical analyses were conducted. To allow for disaggregated analysis by race and ethnicity, the survey responses were recoded into six discrete race and ethnicity categories: white, Black, Latin, Asian, Other Nonwhite, and Undisclosed. For all the findings provided below in aggregate (i.e., not disaggregated by race and ethnicity), the analysis includes weighting by the race and ethnicity factors in order to correct for the disproportionate representation among some racial and ethnic groups in the sample. Cross-tabulations and a chi-square test for significance were conducted to examine the relationship between race and ethnicity and categorical survey responses. A comparison of means and an analysis of variance (ANOVA) test for significance were also used. Both of these tests look at differences across the independent variables as a whole. These tests can show whether the differences observed on the basis of race and ethnicity are different from one another in general, but cannot tell us if answers from one racial and ethnic group are specifically different from another. Given that race and ethnicity have been shown to be substantive factors associated with perceptions of community safety (Whitfield, et al., 2019), and given the limitations with respect to the representativeness of this sample, this analysis is particularly attentive to racial and ethnic differences in responses. All reported differences by race and ethnicity in the findings are statistically significant ($p<.05$) for both chi-square tests and ANOVA test.

LIMITATIONS

The survey sample was not representative of the Berkeley population with regard to race and ethnicity, sexual orientation, zip code, and age. White, older (45 years and older), women, and LGBTQ residents, as well as those who live in the 94702, 94705, and 94707 zip codes, were overrepresented in the sample. Black, Latin, Asian, male, and younger residents were underrepresented in the sample. The nonrepresentative nature of the sample should be noted when interpreting the findings from this survey. The results of this survey are likely to be biased and may not truly reflect community impressions of safety.

See the Appendix for detailed methods and a sample profile.

Summary of Findings

Community Perceptions and Priorities for Safety in Berkeley

Perceptions of Safety in Berkeley

The respondents expressed a range of perspectives regarding the safety of Berkeley, with a plurality selecting "Somewhat safe" in response to this item. Respondents who indicated they are white were more likely to perceive Berkeley as safe and very safe. Respondents who are Black or Other Nonwhite were significantly more likely to perceive Berkeley as unsafe and very unsafe. Respondents who identified as Latin and Asian were more likely than white respondents, but less likely than Black and Other Nonwhite respondents, to perceive Berkeley as unsafe and very unsafe. Unexpectedly, respondents who declined to indicate their race and ethnicity were the most likely to perceive Berkeley as unsafe and very unsafe.

It is worth noting that while Middle Eastern / North African and Native Americans each represented a small number of the respondents (42 and 33, respectively), they were substantially more likely to perceive Berkeley as unsafe and very unsafe than most other racial and ethnic groups (52% and 42%, respectively). Similarly, Pacific Islander / Native Hawaiian respondents represented a small number (N = 22) but were substantially less likely to perceive Berkeley as safe and very safe (0%), but they were not more likely to indicate it as unsafe with 60% selecting somewhat safe.

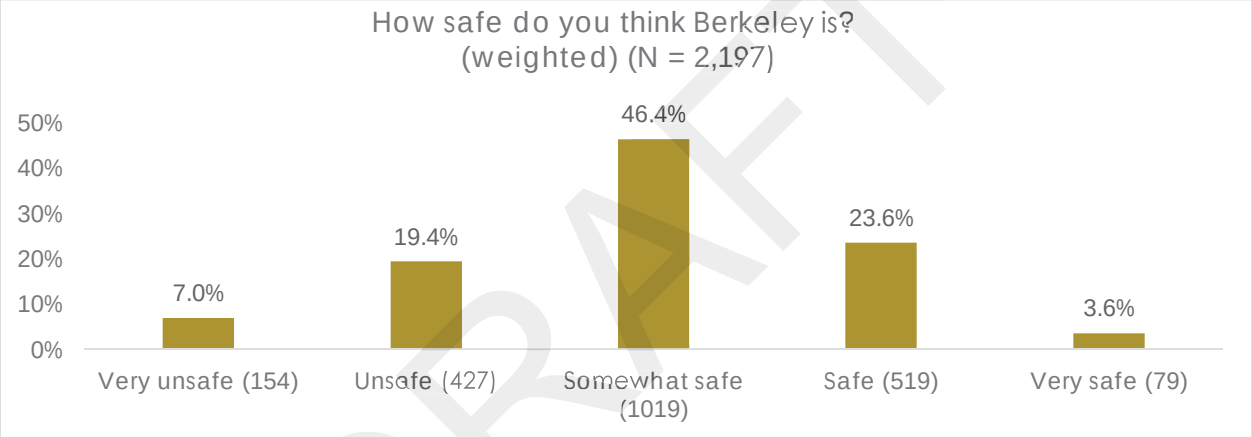


Table 1. How safe do you think Berkeley is? By race and ethnicity.

	White N = 1,622	Black N = 139	Latin N = 103	Asian N = 159	Other Nonwhite N = 168	Undisclosed N = 478
Very unsafe	4.0%	14.4%	9.7%	7.5%	15.5%	19.5%
Unsafe	14.7%	25.9%	25.2%	24.5%	23.2%	34.9%
Somewhat safe	50.5%	36.0%	46.4%	45.3%	46.4%	33.1%
Safe	26.2%	22.3%	13.1%	20.8%	13.1%	10.0%
Very safe	4.6%	1.4%	1.8%	1.9%	1.8%	2.5%

Resident Priorities for Safety

Survey respondents ranked homelessness and sexual assault as the most important public safety concerns, followed by shootings and homicides and mental health crisis. Respondents ranked substance use, drug sales, and police violence as their lowest priorities.

Some responses varied on the basis of the respondents' race and ethnicity—although the differences were not large—and patterns were fairly consistent across the array of race and ethnicity groups, with the exception of the respondents with an undisclosed race and ethnicity. Notably, this group collectively rated police violence substantially lower in importance to community health and safety as compared with other groups. This group was also far more likely to indicate that theft was an important issue in Berkeley.

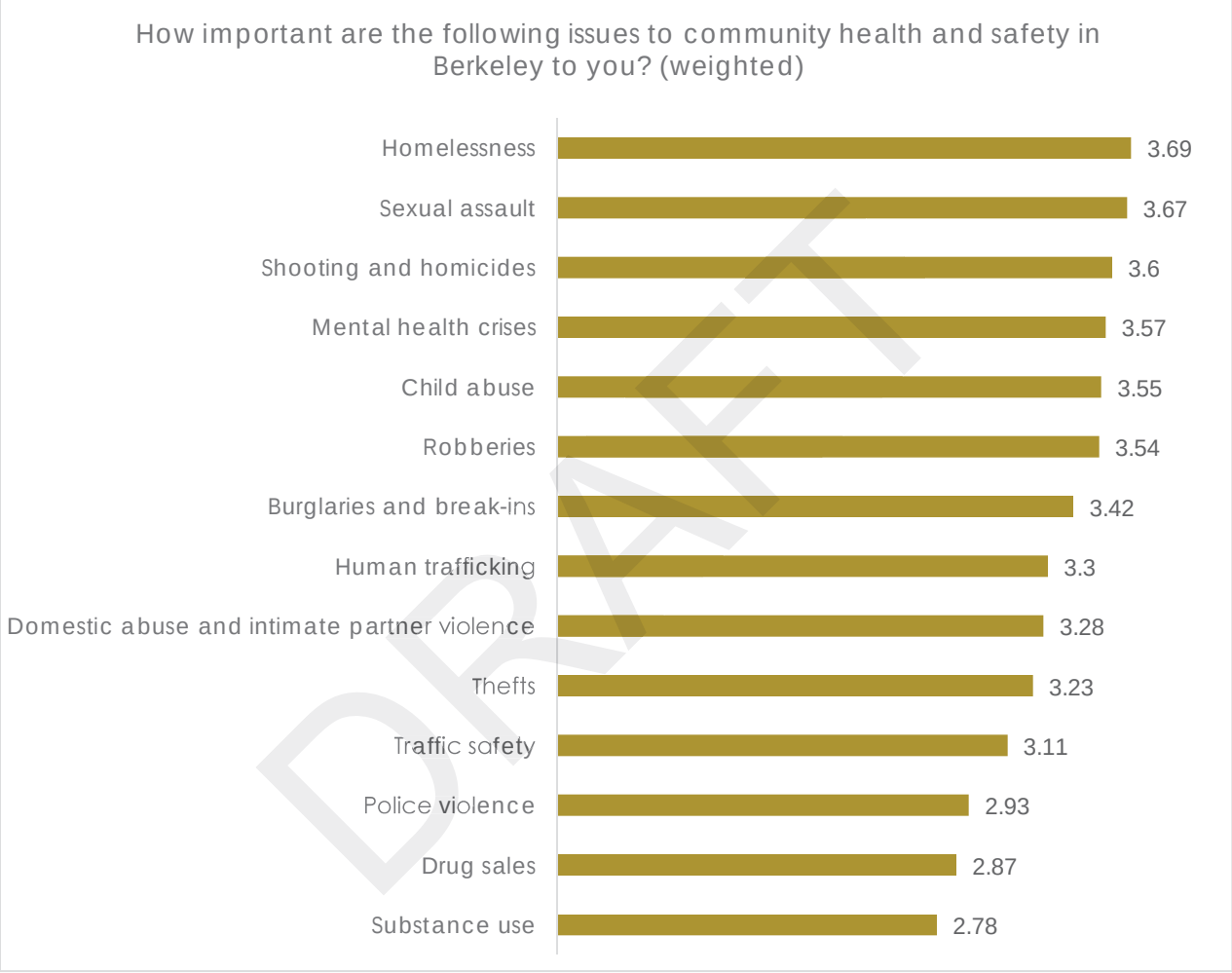


Table 2. How important are the following issues to community health and safety in Berkeley to you? By race and ethnicity.

	White	Black	Latin	Asian	Other Nonwhite	Undisclosed
Substance use	2.68	2.97	2.73	2.91	2.95	2.97
Drug sales	2.77	3.00	2.86	3.01	3.03	3.14
Police violence	3.00	2.90	2.74	2.95	2.76	2.34
Traffic safety	3.07	3.24	3.09	3.13	3.22	3.18
Thefts	3.16	3.35	3.26	3.32	3.25	3.57
Domestic abuse and Intimate partner violence	3.28	3.31	3.34	3.23	3.24	3.18
Human trafficking	3.27	3.48	3.38	3.23	3.42	3.27
Burglaries and break-ins	3.35	3.51	3.46	3.50	3.46	3.73
Robberies	3.46	3.67	3.59	3.64	3.56	3.82
Child abuse	3.54	3.68	3.63	3.47	3.63	3.55
Mental health crises	3.59	3.68	3.50	3.54	3.48	3.45
Shooting and homicides	3.51	3.77	3.69	3.67	3.68	3.77
Sexual assault	3.61	3.80	3.77	3.70	3.77	3.71
Homelessness	3.71	3.59	3.65	3.73	3.59	3.60

Priorities for Community Health and Safety

The mean responses show the highest community support for investment in mental health services, with investment in homeless services programs and violence prevention program also rating fairly high. There are some differences along race and ethnicity in terms of investment priorities, with white respondents rating all listed program investments higher overall, and those with an undisclosed race and ethnicity rating all listed program investments lower overall. While all racial and ethnic groups rated mental health services higher than the other listed program investments, Black respondents rated it particularly high in comparison to other investment options.

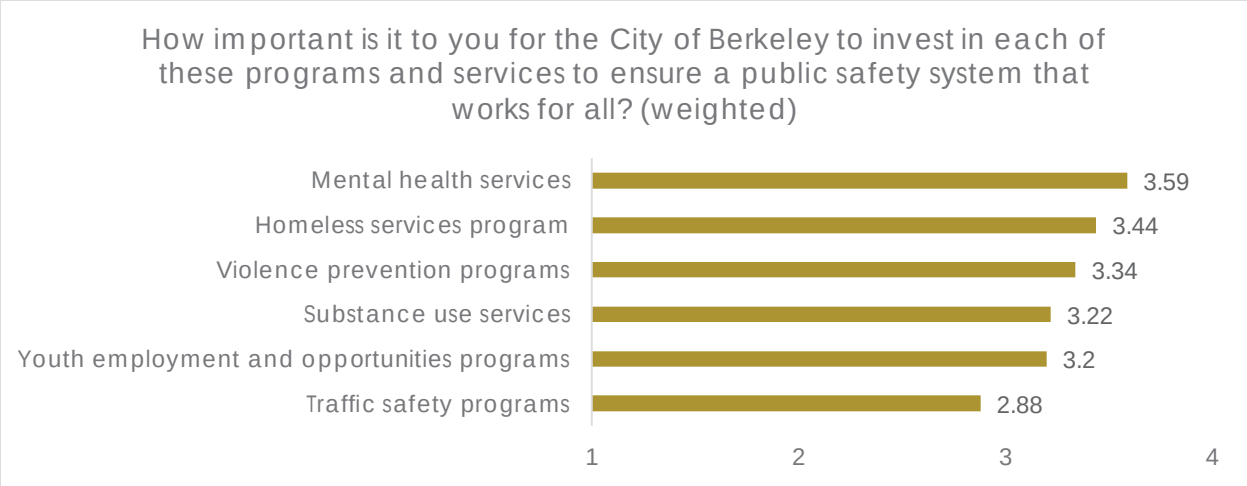


Table 3. How important is it to you for the City of Berkeley to invest in each of these programs and services to ensure a public safety system that works for all? By race and ethnicity.

	White	Black	Latin	Asian	Other Nonwhite	Undisclosed
Traffic safety programs	2.91	2.90	2.77	2.84	3.02	2.81
Youth employment and opportunities programs	3.26	2.99	3.23	3.15	3.14	2.74
Substance use services	3.27	3.03	3.21	3.19	3.17	2.81
Violence prevention programs	3.35	3.19	3.32	3.33	3.41	3.06
Homeless services program	3.56	3.12	3.26	3.44	3.22	2.86
Mental health services	3.69	3.48	3.46	3.53	3.43	3.15

Experiences in Berkeley

Nearly half of the respondents reported experiencing street harassment, and 41% reported being the victim of a crime. Differences along race and ethnicity appear on a number of self-reported personal experiences. Black respondents were more likely to indicate that they have experienced multiple incidents and conditions, including arrest, police harassment, a mental health crisis, homelessness, family victimization, and crime victimization.

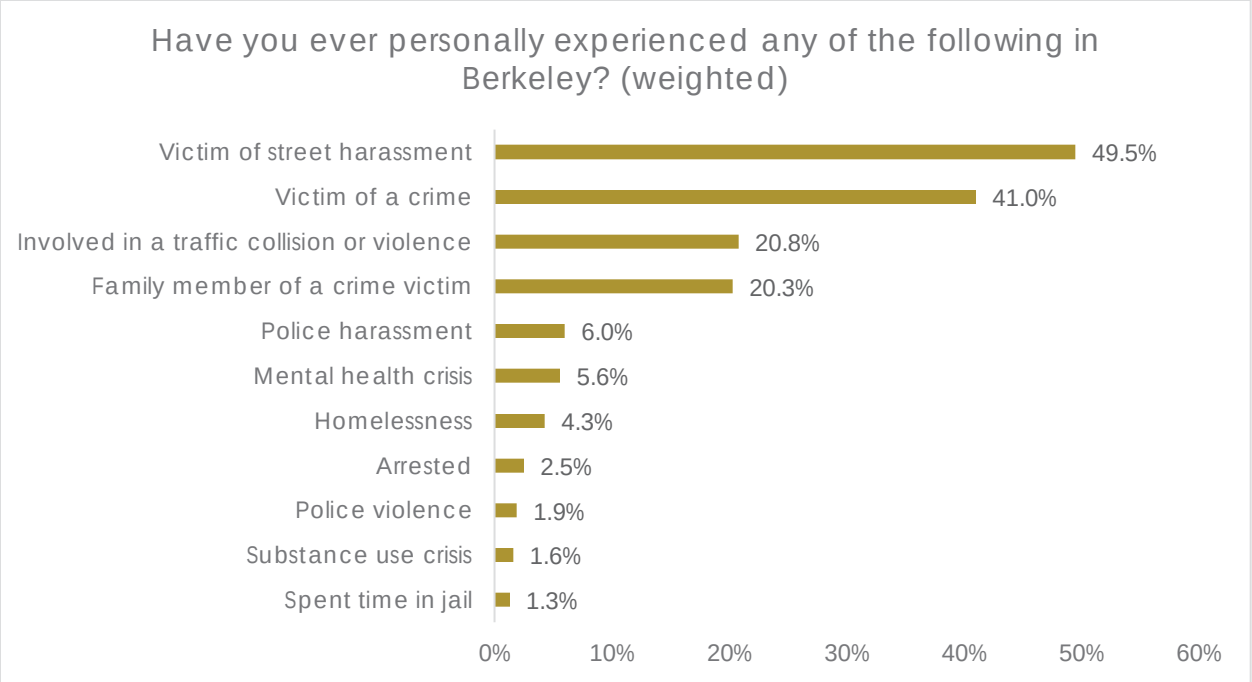
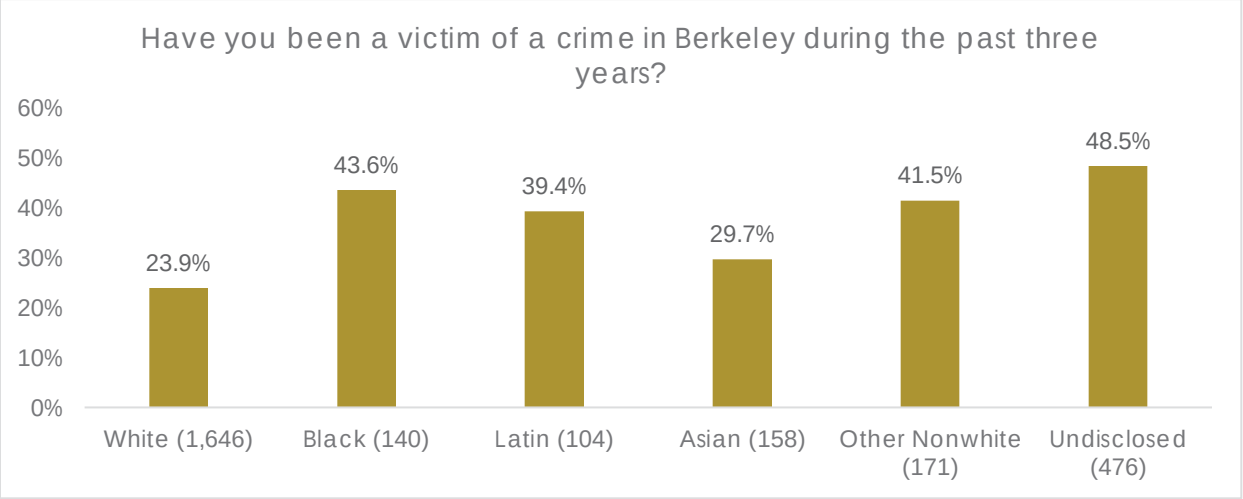


Table 4. Have you personally experienced any of the following in Berkeley? By race and ethnicity.

	White	Black	Latin	Asian	Other Nonwhite	Undisclosed
Spent time in jail	1.3%	5.0%	1.9%	0.0%	.6%	1.4%
Substance use crisis	1.3%	4.3%	4.8%	0.0%	1.7%	1.0%
Police violence	1.5%	2.1%	2.9%	2.5%	1.7%	.8%
Arrested	1.8%	7.1%	4.8%	1.9%	.6%	2.2%
Homelessness	3.1%	12.1%	7.6%	1.9%	6.4%	6.6%
Mental health crisis	5.1%	8.6%	7.6%	4.3%	5.8%	6.2%
Police harassment	4.3%	17.1%	7.6%	5.0%	6.4%	4.0%
Family member of a crime victim	17.0%	35.0%	24.8%	16.8%	32.0%	32.5%
Involved in a traffic collision or violence	20.5%	22.9%	20.0%	21.1%	20.3%	25.9%
Victim of a crime	40.2%	50.7%	43.8%	37.3%	43.0%	53.3%
Victim of street harassment	43.1%	55.7%	61.9%	52.2%	64.0%	64.1%

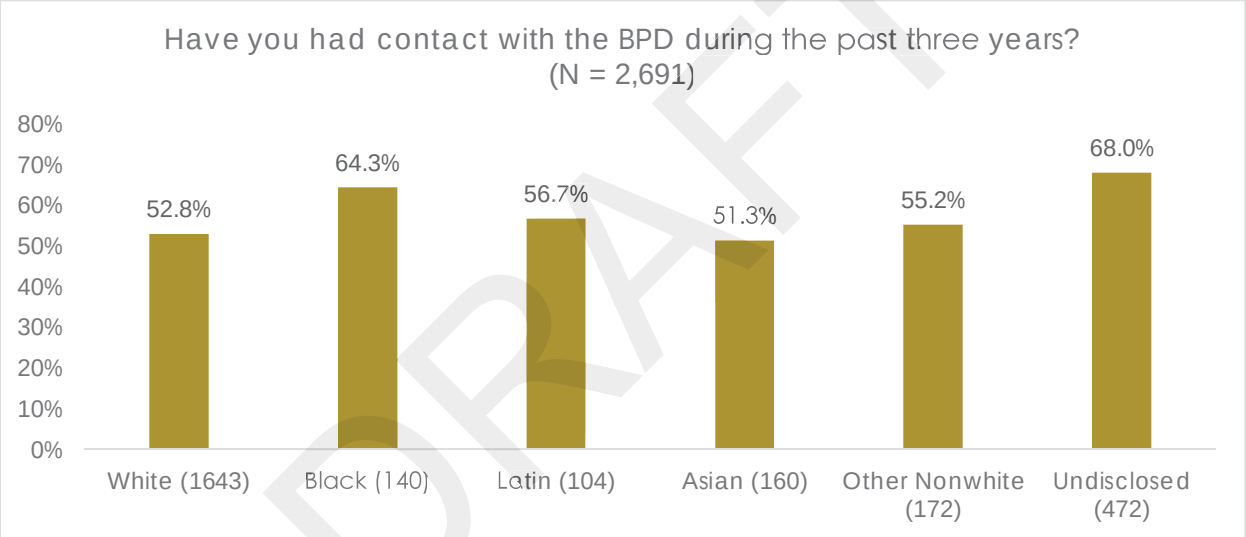
Crime Victimization

Approximately 30% of the respondents indicated having been a crime victim in the City of Berkeley during the past three years. Respondents who are Black and who declined to disclose race and ethnicity were the most likely to indicate that they have been the victim of a crime in Berkeley during the past three years. White respondents were the least likely to do so.



Experience with the Berkeley Police Department

Over half of the respondents (54%) indicated that they have had contact with the Berkeley Police Department (BPD) during the past three years. Respondents who are Black and who declined to disclose race and ethnicity were the most likely to report that they have had contact with the BPD during the past three years.



Perceived Effectiveness of the Berkeley Police Department

Many respondents (38%) perceived the department to be somewhat effective and over half (55.3%) perceived it to be effective or very effective. Only a small number and percentage of the respondents (6.7%) indicated that the Berkeley Police Department is not effective at all.

Some differences in perceived effectiveness of the Berkeley Police Department emerged when the data were disaggregated by race and ethnicity. Nonwhite respondents were more likely to indicate that the

BPD is not effective at all; Asian and Latin respondents were more likely to indicate that the BPD is somewhat effective; and white respondents were more likely to indicate that the BPD is effective. Black residents held diverse views regarding the BPD, and the analysis found that they were more likely to view the BPD as either very effective or not effective at all compared to other groups. Those with undisclosed race and ethnicity were more likely to indicate that the BPD is very effective.

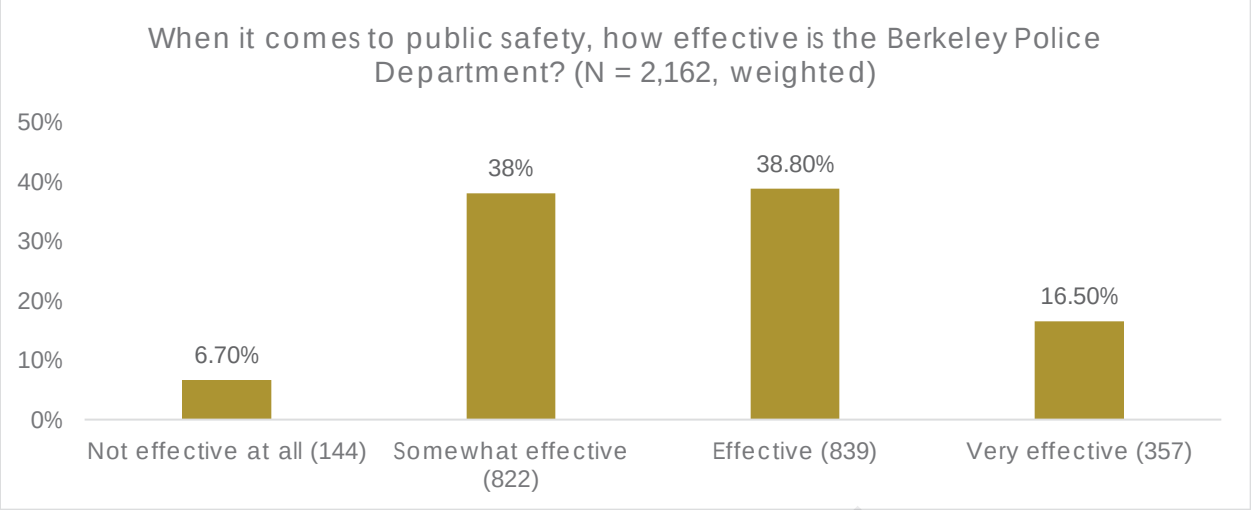


Table 5. When it comes to public safety, how effective is the Berkeley Police Department? By race and ethnicity.

	White N = 1,599	Black N = 136	Latin N = 103	Asian N = 154	Other Nonwhite N = 167	Undisclosed N = 462
Not effective at all	6.8%	8.8%	4.9%	5.2%	10.2%	5.2%
Somewhat effective	36.3%	36.0%	41.7%	43.5%	30.5%	35.9%
Effective	43.4%	27.2%	32.0%	35.1%	39.5%	34.0%
Very effective	13.4%	27.9%	21.4%	16.2%	19.8%	24.9%

Trust that the Berkeley Police Department treats all people fairly and equitably

A little over half of the respondents trust the BPD to usually treat people fairly and equitably, with the remaining 26% demonstrating low confidence in the police on this measure. A minority of the respondents (22%) always trust the BPD to treat people fairly and equitably. Some differences emerged along race and ethnicity with respect to confidence in the BPD to exercise fairness and equity. Black and Latin respondents hold a variety of perspectives on police. They were more likely than other groups to either not trust the BPD or to have confidence in them. Respondents with an undisclosed race and ethnicity were the most likely to demonstrate confidence in the BPD in this regard, and the least likely to demonstrate low confidence.

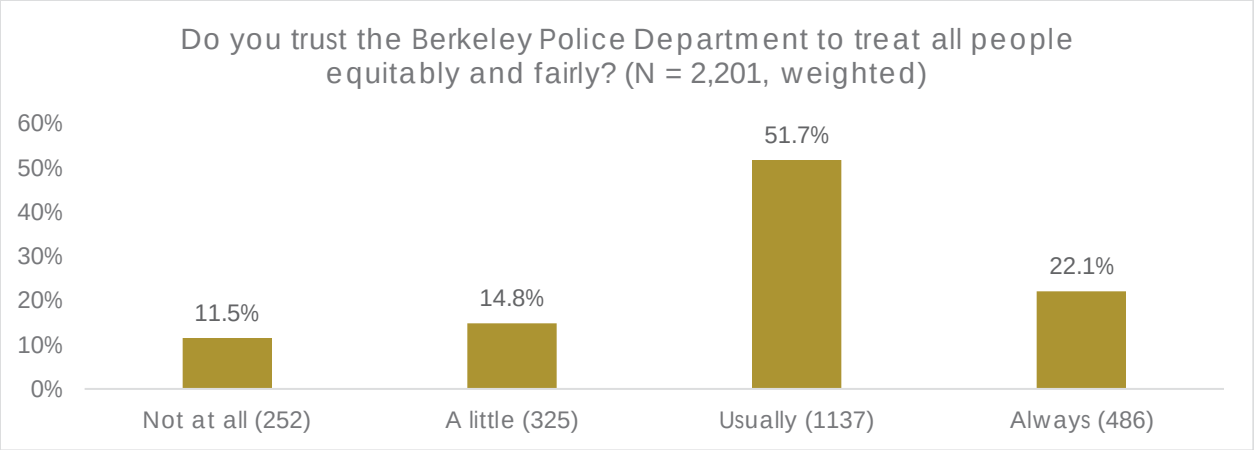


Table 6. Do you trust the Berkeley Police Department to treat all people equitably and fairly? By race and ethnicity.

	White (N = 1,632)	Black (N = 139)	Latin (N = 102)	Asian (N = 159)	Other Nonwhite (N = 169)	Undisclosed (N = 474)
Not at all	10.3%	16.5%	16.7%	10.1%	10.7%	3.0%
A little	16.1%	12.9%	12.7%	13.9%	12.4%	8.2%
Usually	55.0%	38.8%	37.3%	56.3%	48.5%	44.9%
Always	18.6%	31.7%	33.3%	19.6%	28.4%	43.9%

Quality of Experience with the Berkeley Police Department

Among the respondents who indicated that they've had contact with the BPD and chose to report on the quality of those experiences, three out of four (74.8%) indicated that the experience was positive or very positive. Differences in experiences with police across race and ethnicity include Black and Asian respondents as the most likely to report negative experiences, and respondents with undisclosed race and ethnicity as the least likely to report negative experiences and the most likely to report positive experiences with the BPD.

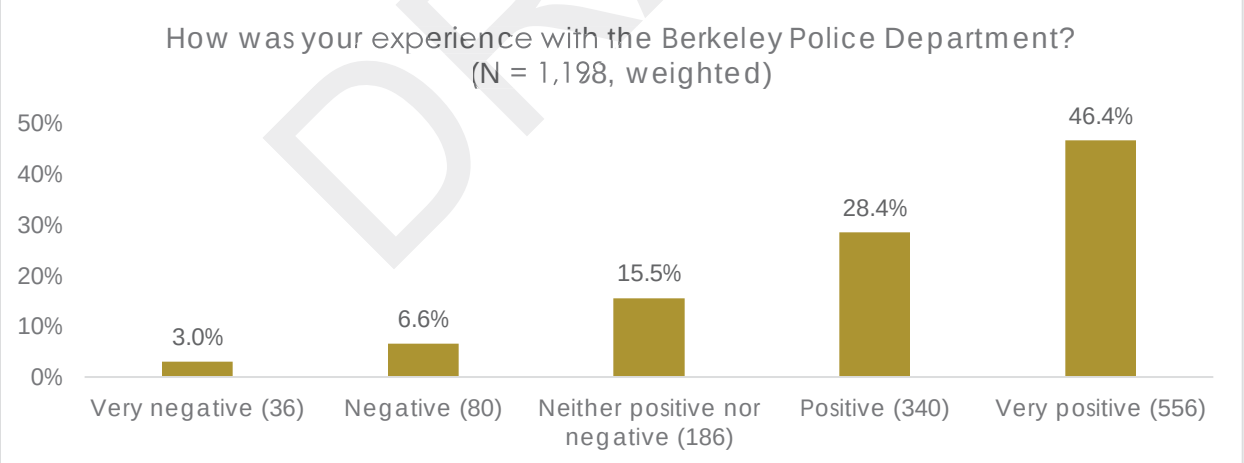


Table 7. How was your experience with the Berkeley Police Department? By race and ethnicity.

	White N = 864	Black N = 90	Latin N = 59	Asian N = 82	Other Nonwhite N = 95	Undisclosed N = 318
Very negative	2.3%	4.4%	5.1%	2.4%	4.2%	0.6%
Negative	6.1%	6.7%	1.7%	11.0%	5.3%	3.8%
Neither positive nor negative	17.0%	13.3%	20.3%	11.0%	13.7%	12.6%
Positive	31.0%	21.1%	18.6%	31.7%	25.3%	15.1%
Very positive	43.5%	54.4%	54.2%	43.9%	51.6%	67.9%

Likelihood to call Emergency Responses

Respondents are far more likely to call 911 in response to an emergency situation *not* involving mental health or substance use (86.2%) than they are to an emergency that does relate to a mental health or substance use crisis (57.9%). Over half of the respondents did, however, indicate that they are likely or very likely to call 911 in response to a mental health or substance-use-related crisis (57.9%).

Black and Latin respondents indicated a wide range of responses to the question regarding their likelihood of calling the 911 in response to a mental health or substance use crisis. On the other hand, racial and ethnic groups responded similarly in response to the question about calling 911 when there's an emergency *not* related to mental health or substance use. Substantially more Black respondents indicated extreme reluctance as compared with other groups.

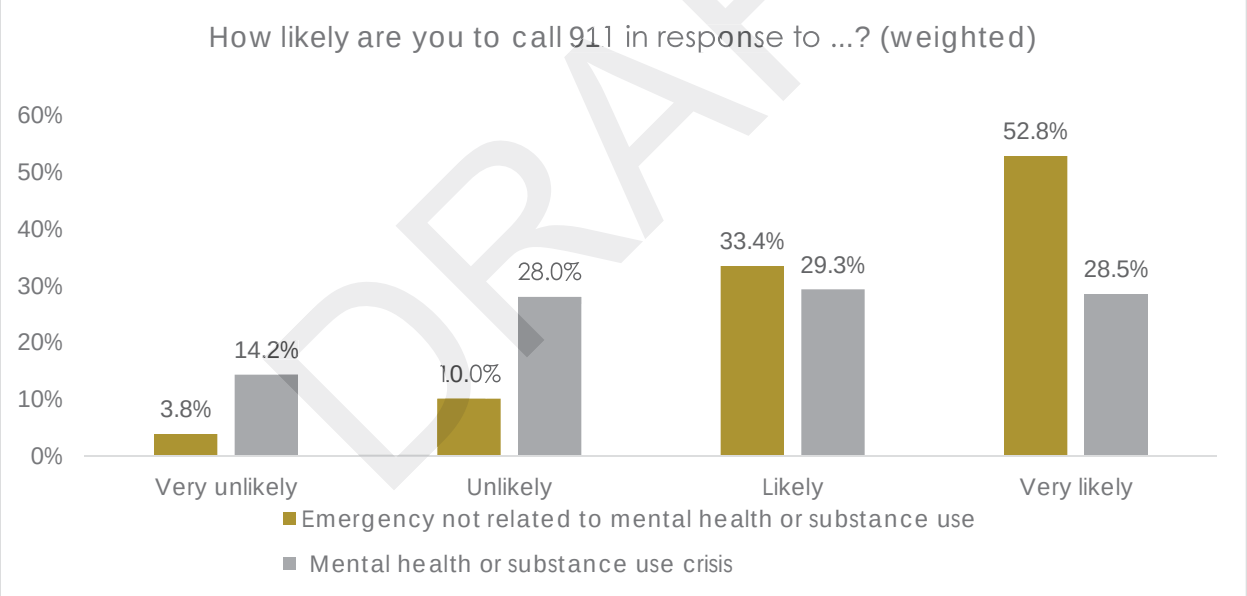


Table 8. How likely are you to call emergency services (911) in response to an emergency NOT related to a mental health or substance use crisis? By race and ethnicity.

	White N = 1,632	Black N = 140	Latin N = 104	Asian N = 156	Other Nonwhite N = 171	Undisclosed N = 468
Very unlikely	3.7%	9.3%	3.8%	1.9%	2.9%	4.1%
Unlikely	10.9%	11.4%	7.7%	8.3%	10.5%	9.8%
Likely	33.8%	27.9%	33.7%	34.6%	32.2%	26.7%
Very likely	51.5%	51.4%	54.8%	55.1%	54.4%	59.4%

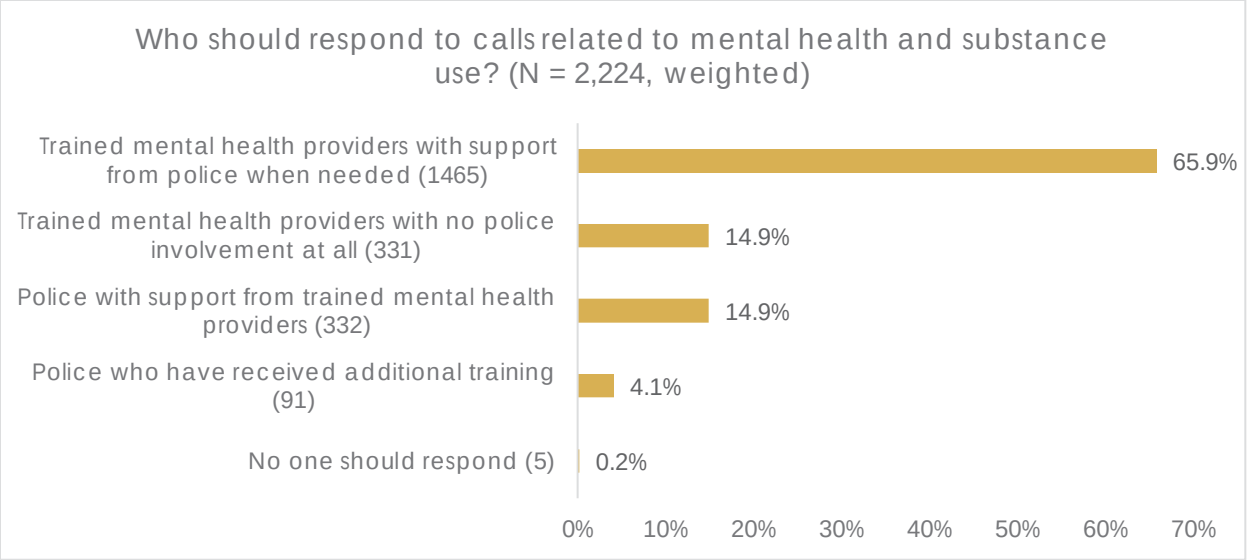
Table 9. How likely are you to call emergency services (911) in response to a mental health or substance use crisis? By race and ethnicity.

	White N = 1,628	Black N = 140	Latin N = 104	Asian N = 158	Other Nonwhite N = 170	Undisclosed N = 471
Very unlikely	15.2%	20.0%	20.2%	6.3%	14.7%	15.9%
Unlikely	26.7%	25.0%	20.2%	35.4%	31.2%	22.9%
Likely	30.8%	20.7%	21.2%	32.9%	28.8%	28.5%
Very likely	27.4%	34.3%	38.5%	25.3%	25.3%	32.7%

PREFERENCE FOR CRISIS RESPONSE

A large majority of the respondents (80.8%) indicated a preference for trained mental health providers to respond to calls related to mental health and substance use, with most among those respondents indicating that police support should be available when needed. Some respondents (19%) indicated a preference for a police response, with over two-thirds of those respondents indicating that mental health providers should be available for support.

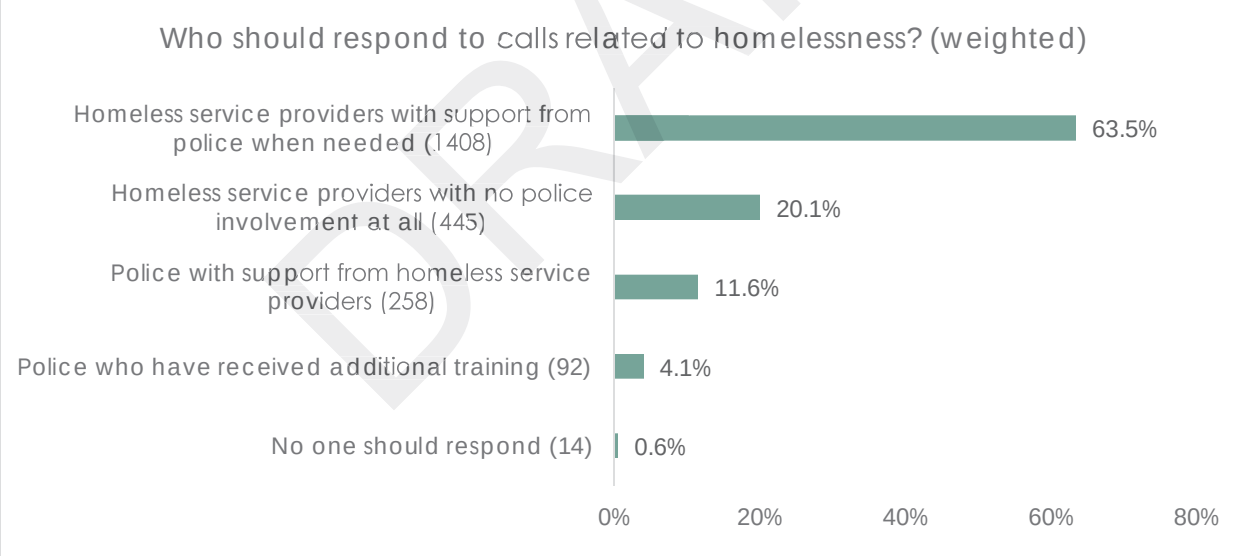
All racial and ethnic groups show a preference for "Trained mental health providers, with support from police when needed" to respond to calls related to mental health and substance use. Respondents whose race and ethnicity were undisclosed were the most likely to prefer a police response (42%) in comparison to other groups.



PREFERENCE FOR RESPONSE TO HOMELESSNESS

A large majority of the respondents (83.6%) indicated a preference for homeless services providers to respond to calls related to homelessness, with most among those respondents indicating that police support should be available when needed. Some of the respondents (15.7%) indicated a preference for a police response, with the majority of those respondents indicating that homeless services providers should be available for support.

All racial and ethnic groups show a preference for homeless services providers, with support from police when needed to respond to calls related to homelessness. Respondents whose racial and ethnic were undisclosed were the most likely to prefer a police response (41%) in comparison to other groups.



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APPENDIX

SAMPLE PROFILE

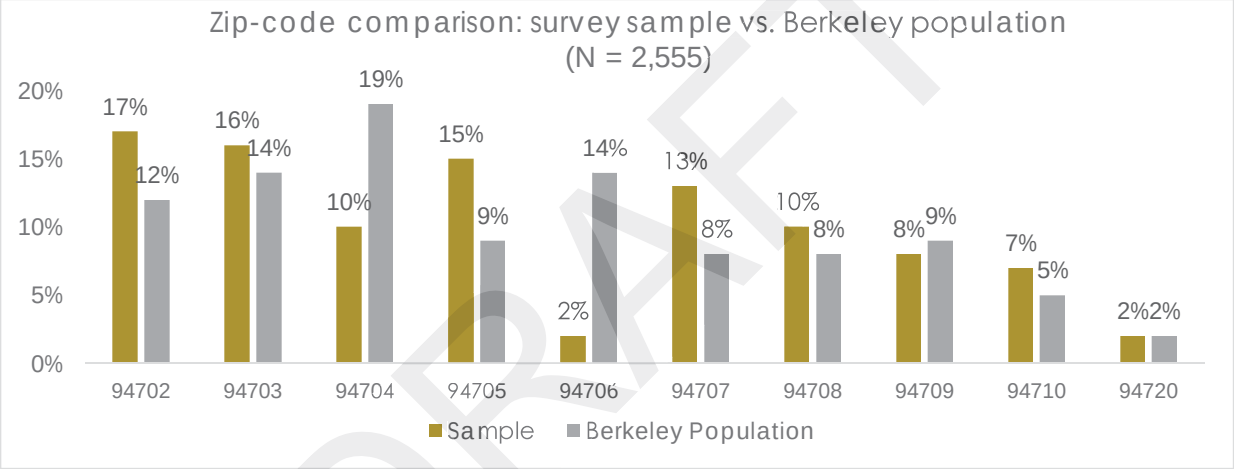
Relationship to City of Berkeley

The vast majority of the survey respondents live in Berkeley (84.4%). A portion work in Berkeley (but don't live there), and a small number have other situations or provided no information. Notably, very few houseless residents responded to the survey.

Live or work in Berkeley (N = 2,729)	**Percent**
Live in Berkeley	84.4%
Work in Berkeley	12.0%
I am currently experiencing homelessness	0.1%
I do not live or work in Berkeley	2.3%
No information	1.1%

Zip Code

The Berkeley population is spread out primarily across the 10 zip codes listed in the table and chart below, which compare the survey responses with Berkeley population figures.[1] These data show that certain zip codes are overrepresented in the sample (e.g., 94702, 94705, 94707), while others are underrepresented (e.g., 94704, 94706).



Age

The sample skews significantly toward older respondents, with approximately 70% of the respondents who provided information on their age identifying themselves as 45 years or older, and over 40% of the respondents identifying themselves as 60 years or older. By comparison, among the adult population of

[1] Zip-code data for the residents of Berkeley from Zip-code.com. Retrieved on 6/24/21 from https://www.zip-codes.com/city/ca-berkeley.asp.

Berkeley, 42% is estimated to be 45 or older, and only 25% is estimated to be 60 or older.[2] Note that there were 55 respondents who did not respond to this question.

Age Range (N = 2,674)	**Percent**
Under 14 years (1)	0.04%
14–17 (3)	0.1%
18–29 (182)	6.8%
30–44 (21)	23.2%
45–59 (788)	29.5%
60+ years (1,079)	40.4%

Sexual Orientation

Of the respondents who responded to the question pertaining to sexual orientation (84 respondents declined to answer the question), 67% indicated that they are heterosexual or straight; nearly 17% indicated a preference not to disclose; and approximately 16% indicated a sexual orientation generally classified under the umbrella of LGBTQ. While there are no reliable existing figures to show the percentage of the LGBTQ population among Berkeley residents, it is reasonable to speculate that the LGBTQ population is overrepresented in the sample on the basis of recent figures estimating that the LGBTQ population in the wider Bay Area is 6.7% (Conron, et al., 2021). Furthermore, new analyses show that younger populations are more likely to indicate an LGBTQ identification as compared with older populations (Jones, 2021). Given this research and the age of the sample, one would anticipate a lower-than-average LGBTQ percentage in the sample rather than a higher-than-average percentage—which again suggests over-sampling of the LGBTQ population.

Sexual Orientation (N = 2,645)	**Percent**
Heterosexual or straight (1,771)	67.0%
Prefer not to say (447)	16.9%
Gay or lesbian (155)	5.9%
Bisexual (133)	5.0%
Queer (72)	2.7%
Questioning or unsure (16)	0.6%
Other, please specify (51)	1.9%

[2] Population estimates from Census Reporter. Retrieved on 6/24/21 from https://censusreporter.org/profiles/16000US0606000-berkeley-ca/.

Gender Identity

In terms of gender, men are underrepresented in the sample. A substantial portion of the respondents (nearly 10%) preferred not to disclose their gender identity.

Gender Identity (N = 2,662)	**Percent**
Woman (1,439)	54.1%
Man (893)	33.5%
Genderqueer / nonbinary / other (73)	2.7%
Prefer not to say (257)	9.7%

Race and Ethnicity

The table below represents all survey responses to the question of race and ethnicity before any recoding or weighting, so the total number exceeds the number of respondents. Please note that for this survey, respondents were invited to select all racial and ethnic categories that applied to them. In other words, an individual who selected White, as well as Black or African American and South Asian is counted three times in the table below.

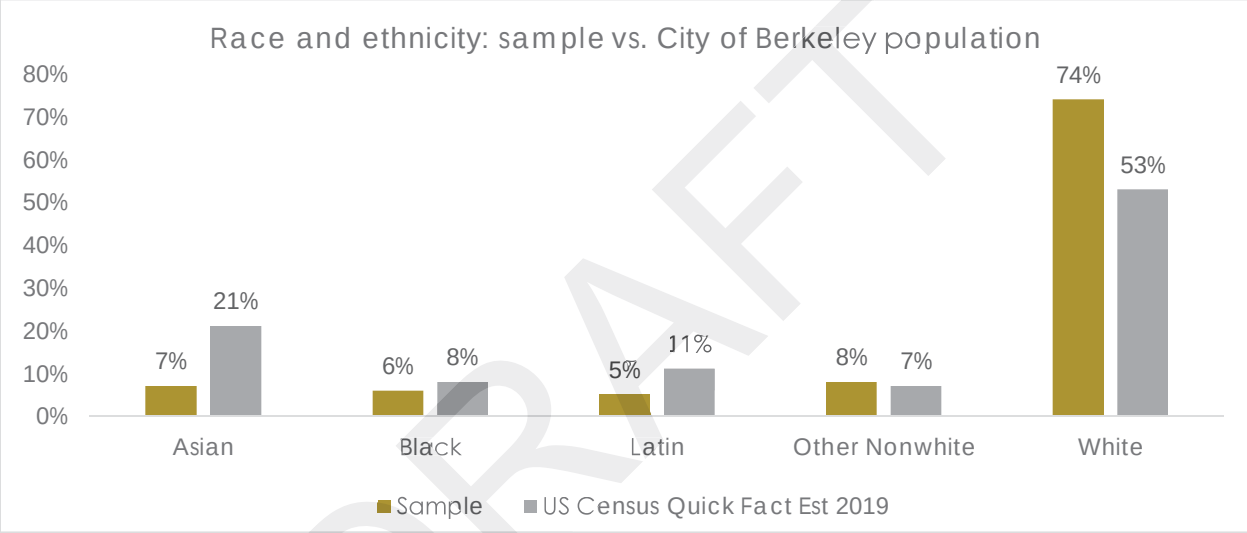
Race and ethnicity	**Number**	**% of Total**
White	1787	65.5%
Black or African American	137	5.0%
Latin	126	4.6%
East Asian	168	6.2%
South East Asian	53	1.9%
South Asian	47	1.7%
Middle Eastern / North African	42	1.5%
American Indian / Native American / Alaskan Native	33	1.2%
Pacific Islander or Native Hawaiian	22	0.8%
Other	113	4.1%
Prefer not to say	409	15.0%

In order to simplify the data to allow for disaggregated analyses and to enable the creation of a weighting scheme, the analysts created a reduced number of discrete (i.e., not overlapping) racial and ethnic categories. To condense the data into discrete categories, the data were recoded in the following manner:

- White: Respondents who selected only White as their race and ethnicity were coded as white; respondents who selected "Other" and then wrote in only an ethnicity that is considered white (e.g., European, Irish, Jewish, etc.) were coded as white.
- Black: Respondents who selected Black were coded as Black, even if they also selected other racial and ethnic identities.

- Latin: Respondents who had selected Latin were coded as Latin, even if they also selected other racial and ethnic identities (unless they also selected Black, in which case they were recoded as Black).
- Asian: Respondents who selected East Asian, Southeast Asian, or Other and then wrote in an ethnicity that is considered Asian (e.g., Japanese, Chinese, etc.) were coded as Asian, even if they also selected other racial and ethnic identities (besides Black or Latin)
- Other Nonwhite: All other nonwhite racial and ethnic categories were combined into a single "Other Nonwhite" variable, including Native American / Alaskan, South Asian, Arab / Middle Eastern, and Pacific Islander / Native Hawaiian, as well as anyone who selected multiple racial and ethnic identities that did not include Black, Latin, or Asian, and anyone who selected "Other" and then wrote in an ethnicity that was outside the aforementioned categories.

Notably, after White the most common response in the data set was "Prefer not to say," which was recoded to include blank responses as well as anyone who selected "Other" and then wrote in a nonresponsive category (e.g., "human race," "race does not exist," or "irrelevant"). These respondents comprise 18% of the sample (478 out of 2,708) and are listed as Undisclosed under race and ethnicity. In the disaggregated analyses, their responses are included to show how this group's answers differed from those of other groups, but for the purposes of devising a weighting scheme on the basis of race and ethnicity, these respondents are omitted, as the race and ethnicity data for them is essentially missing.



	Sample		Berkeley Population US Census QuickFacts Est. 2019	Weighting Factor
Asian	161	7%	21%	3
Black	140	6%	8%	1.333
Latin	105	5%	11%	2.2
Other Nonwhite	172	8%	7%	0.875
White	1652	74%	53%	0.716
Subtotal	2230	100%	100%	--

Undisclosed	478	18%	--	--
Total sample	2708	100%	--	--

The Berkeley Community Safety survey sample (respondent population) is not representative of the Berkeley population in terms of race and ethnicity. The table above shows the breakdown of race and ethnicity for the Berkeley population and the sample (for the respondents who provided race and ethnicity information).

For all findings provided below in aggregate (i.e., not disaggregated by race and ethnicity), the analysis includes weighting by the race and ethnicity factor (as listed above) in order to correct for the disproportionate representation of some racial and ethnic groups in the sample. So, for example, respondents who are Asian comprise only 7% of the sample but 21% of the Berkeley population. So in the frequency tables in the findings section, responses from Asian-identified respondents are amplified by a factor of 3. Similarly, white and Other Nonwhite respondents are overrepresented in the sample, so the value of their responses is discounted to 71.6% and 87.5% of their original value, respectively.

Race and ethnicity by Zip Code

Ethnicity		Blank	94701	94702	94703	94704	94705	94706	94707	94708	94709	94710	94712	94720	Not sure	Total
White	#	48	4	264	247	126	264	33	229	186	129	91	1	25	5	1652
	%	2.9%	.2%	16.0%	15.0%	7.6%	16.0%	2.0%	13.9%	11.3%	7.8%	5.5%	.1%	1.5%	.3%	100.0%
Black	#	4	0	31	24	16	11	2	6	9	7	24	0	4	2	140
	%	2.9%	0.0%	22.1%	17.1%	11.4%	7.9%	1.4%	4.3%	6.4%	5.0%	17.1%	0.0%	2.9%	1.4%	100.0%
Latin	#	3	0	18	15	15	22	7	7	5	4	6	0	0	3	105
	%	2.9%	0.0%	17.1%	14.3%	14.3%	21.0%	6.7%	6.7%	4.8%	3.8%	5.7%	0.0%	0.0%	2.9%	100.0%
Asian	#	7	0	27	27	19	14	2	10	18	19	11	0	7	0	161
	%	4.3%	0.0%	16.8%	16.8%	11.8%	8.7%	1.2%	6.2%	11.2%	11.8%	6.8%	0.0%	4.3%	0.0%	100.0%
Other Nonwhite	#	11	1	19	23	28	15	6	15	18	15	13	0	7	1	172
	%	6.4%	.6%	11.0%	13.4%	16.3%	8.7%	3.5%	8.7%	10.5%	8.7%	7.6%	0.0%	4.1%	.6%	100.0%
Undisclosed	#	63	3	72	75	56	56	8	53	32	25	30	0	8	18	499
	%	12.6%	.6%	14.4%	15.0%	11.2%	11.2%	1.6%	10.6%	6.4%	5.0%	6.0%	0.0%	1.6%	3.6%	100.0%
Total	#	136	8	431	411	260	382	58	320	268	199	175	1	51	29	2729
	%	5.0%	.3%	15.8%	15.1%	9.5%	14.0%	2.1%	11.7%	9.8%	7.3%	6.4%	.0%	1.9%	1.1%	100.0%

CITY OF BERKELEY REIMAGINING PUBLIC SAFETY SURVEY

If you would like to take this survey in Spanish, please select Spanish on the right (in the black bar above).

Si le gustaría responder a esta encueta en español, por favor escoja "Español" a la derecha (en la barra color negro que aparece arriba).

The City of Berkeley is looking to create a community safety model that reflects the needs of the community. We invite those who live, work, and study in the City of Berkeley to provide their input on the following:

- The current state of public safety in Berkeley
- The role of the Berkeley Police Department
- Your ideas for the future

Your participation in the survey will inform our decisions about funding and strategy for community safety in Berkeley.

We want your honest feedback and perspective. ***Your survey responses are completely anonymous and confidential.*** You can skip any questions and end the survey at any time. Only Bright Research Group, a third-party outside research firm, will have access to the survey responses. Bright Research Group will summarize de-identified survey responses in a report to the City of Berkeley.

If you have any questions, please contact David White at rpstf@cityofberkeley.info.

Community Safety

1) How safe do you think Berkeley is?

Very safe

Safe

Somewhat safe

Unsafe

Very unsafe

2) For you, what would make Berkeley a safer city?

3) How important are the following issues to community health and safety in Berkeley to you? Please rate each of the issues.

	Very important	**Important**	**Somewhat important**	**Not important**
Shooting and homicides				
Robberies				
Domestic abuse and intimate partner violence				
Sexual assault				
Child abuse				
Burglaries and break-ins				
Thefts				
Traffic safety				
Mental health crises				
Homelessness				
Drug sales				
Substance use				
Human trafficking				
Police violence				

4) Have you personally experienced any of the following in Berkeley? Please check all that apply.

Homelessness

Arrested

Spent time in jail

Victim of a crime

Family member of a crime victim

Victim of street harassment

Involved in a traffic collision or traffic violence

Mental health crisis

Substance use crisis

Police harassment

Police violence

None of the above

5) Have you been a victim of a crime in the City of Berkeley in the past 3 years?

Yes

No

6) Have you had contact with the Berkeley Police Department in the past 3 years?

Yes

No

7) How was your experience with the Berkeley Police Department?

Very positive

Positive

Neither positive nor negative

Negative

Very negative

8) What recommendations do you have to improve police response?

9) When it comes to public safety, how effective is the Berkeley Police Department?

Very effective

Effective

Somewhat effective

Not effective at all

10) Please share examples of how the Berkeley Police Department ***has worked well*** in your community.

If you feel it would be helpful, please describe your community (for example, by race and ethnicity, sex, gender identity or expression, sexual orientation, housing status, age, physical or mental disabilities, class, religion, immigration status).

11) Please share examples of how the Berkeley Police Department ***has not worked well*** in your community.

If you feel it would be helpful, please describe your community (for example, by race and ethnicity, sex, gender identity or expression, sexual orientation, housing status, age, physical or mental disabilities, class, religion, immigration status).

12) Do you trust the Berkeley Police Department to treat all people fairly and equitably?

Always

Usually

A little

Not at all

13) In what ways could the Berkeley Police Department work to build more trust with the community?

Reimagining Public Safety

14) How important is it to you for the City of Berkeley to invest in each of these programs and services to ensure a public safety system that works for all?

	Very important	**Important**	**Somewhat important**	**Not important**
Youth employment and opportunities programs				
Homeless services program				
Mental health services				
Substance use services				
Violence prevention programs				
Traffic safety programs				

15) What other programs and services do we need to invest in within our community to ensure a public safety system that works for all?

As part of the city's Reimagining Public Safety Initiative, the city is developing a pilot program to *reassign noncriminal police service calls to a Specialized Care Unit.*

This Specialized Care Unit (SCU) will consist of trained crisis-response workers who will respond to calls that are determined to be noncriminal and that pose no immediate threat to the safety of community members and/or responding personnel.

Your answers to the following questions will help the city in the design of the pilot program.

16) How likely are you to call emergency services (9-1-1) in response to a mental health or substance use crisis?

Very Likely

Likely

Unlikely

Very unlikely

17) How likely are you to call emergency services (9-1-1) in response to an emergency **not related** *to mental health or substance use ?*

Very likely

Likely

Unlikely

Very unlikely

18) Who should respond to calls related to mental health and substance use?

Trained mental health providers, with no police involvement at all

Trained mental health providers, with support from police when needed

Police, with support from trained mental health providers

Police who have received additional training

No one should respond

19) Who should respond to calls related to homelessness?

Homeless service providers, with no police involvement at all

Homeless service providers, with support of police when needed

Police, with support from homeless service providers

Police who have received additional training

No one should respond

20) Please share any experiences you have had with mental health and/or substance use crisis response services in Berkeley.

21) What recommendations do you have to improve mental health and/or substance use crisis response in Berkeley?

Demographic Information

22) What best describes you?

Live in Berkeley

Work in Berkeley

I am currently experiencing homelessness

I do not live or work in Berkeley

23) Which City of Berkeley zip code do you live or work in?

94701

94702

94703

94704

94705

94706

94707

94708

94709

94710

94712

94720

Not sure

24) How old are you?

Under 14 years

14–17

18–29

30–44

45–59

60+ years

25) What is your race and ethnicity? (Check all that apply.)

Black or African American

Latinx

White

East Asian

South Asian

South East Asian

Pacific Islander or Native Hawaiian

American Indian, Native American, or Alaskan Native

Middle Eastern or North African

Prefer not to say

Other—please specify:

26) Do you identify as transgender?

Yes

No

Unsure / prefer not to say

27) What is your gender?

Woman

Man

Genderqueer

Nonbinary

Other—please specify:

Prefer not to say

28) How would you describe your sexual orientation?

Gay or lesbian

Bisexual

Queer

Questioning or unsure

Heterosexual or straight

Other—please specify: *

Prefer not to say

29) Are you familiar with the City of Berkeley's efforts to reimagine public safety?

Yes

No

30) Would you like to know more about the city's efforts to reimagine public safety?

Yes

No

Thank you!

Thank you for taking our survey! Your response is very important to us. You can find more information about the City of Berkeley's ongoing efforts to reimagine public safety at https://berkeley-rps.org.

CITY OF BERKELEY:
REIMAGINING PUBLIC SAFETY SURVEY—COMMUNITY PERCEPTIONS

Latin Community Perceptions Summary of Findings—July 2021

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INTRODUCTION

The City of Berkeley is working to develop a community-safety model that reflects the needs of the community and creates increased safety for all. In collaboration with the National Institute for Criminal Justice Reform, the City of Berkeley, and the Reimagining Public Safety Task Force, Bright Research Group (BRG) developed and conducted a community survey to gather residents' experiences with and perceptions of the Berkeley Police Department and crisis response, perspectives on and priorities for reimagining public safety, and recommendations for alternative responses for community safety. This report summarizes the key qualitative findings from survey respondents who identified as Latin.

METHODOLOGY

A total of 2,729 survey responses were collected between May 18 and June 15, 2021. The City of Berkeley, the Reimagining Public Safety Task Force, community-based organizations, and other key partners disseminated the community survey through various online channels and websites to those who live, work, and study in Berkeley, in English and Spanish. Respondents completed the survey online.

The survey included the following six open-ended questions related to community perceptions of safety and preferences regarding public safety strategies:

- What recommendations do you have to improve police response?
- Please share examples of how the Berkeley Police Department has *worked well* in your community.
- Please share examples of how the Berkeley Police Department has *not worked well* in your community.
- In what ways could the Berkeley Police Department work to build more trust with the community?
- What other programs and services do we need to invest in within our community to ensure a public safety system that works for all?
- Please share any experiences you have had with mental health and/or substance use crisis response services in Berkeley.

During the research design, Bright Research Group worked with the National Institute for Criminal Justice Reform and the Berkeley City Manager's Office to identify several priority populations for engagement beyond the community survey. The McGee Avenue Baptist Church; the Center for Food, Faith & Justice; and the Berkeley Underground Scholars facilitated outreach to the identified priority populations. Bright Research Group conducted a series of focus groups to gather their perspectives on the current state of public safety, the role of the Berkeley Police Department (BPD), and the future of public safety. Although the focus groups engaged 55 individuals, Latin residents were not well-represented. In order to learn more about the priorities of Latin residents, BRG analyzed the qualitative data responses from survey respondents who identified as Latin. Of the 2,729 survey respondents, 126 individuals identified as Latin. BRG conducted a thematic analysis by qualitative research question. This report documents the key findings and recommendations from this thematic analysis.

Limitations: Of the 126 Latin respondents, only 2 completed the survey in Spanish. This suggests that the opinions, experiences, and preferences of recent immigrant, monolingual Spanish speakers are under-represented. Latin respondents were under-represented in the survey responses and these results may not be generalizable to the city as a whole.

Findings

Community Perceptions and Priorities for Safety in Berkeley

When it comes to feelings of safety in Berkeley, the survey respondents expressed significant concerns related to their safety and the safety of their family members and were dissatisfied with the city's response. Many Latin survey respondents associated the homeless crisis with feeling unsafe in Berkeley. Respondents described homelessness as the source of crime and reason that Berkeley is unsafe. Respondents recounted instances of street harassment by unhoused residents and expressed frustration that many parks, streets, and neighborhoods including downtown are not usable due to blight and on-going street harassment associated with the homeless population. The current state of public spaces in Berkeley negatively impacts Latin residents' quality of life and influences their decisions about how they and their children move through the city. In addition, some Latin respondents expressed concerns about traffic safety and violent crime including gang violence, robberies, and shootings in Berkeley.

> "The city needs to have actual housing with requirements for homeless and facilities that can actually deal with mental health issues as well as drug and alcohol issues. The current county systems do not work."
>
> —Resident

> "The level of people experiencing homelessness that are directly affecting people's day to day lives has gotten to a tipping point. From being accosted on the street to having to swerve while driving from people in encampments....we need to address the homeless issue immediately!"
> —Resident

Overall, Latin respondents expressed dissatisfaction with the city's current approach to public safety and shared a common expectation that city leaders should prioritize cleaning up streets and public parks, installing additional lighting in neighborhoods, improving traffic control, and urgently address the issue of a growing homeless population in Berkeley. Additionally, they called for increased gun control, investments in youth prevention and intervention programs, and more visible police presence, such as officers patrolling on foot and bicycles.

Latin survey respondents *lifted homelessness and the housing crisis as the most critical public safety issues in Berkeley but expressed divergent views about the best way to address the issues.* Many respondents expressed dissatisfaction with the city s current response to homelessness in Berkeley. While residents concurred that the city's current response to homelessness is inadequate and needs to be reconstructed, they offered a wide range of solutions. Recommendations ranged from enforcing a zero-tolerance approach to illegally parked RV's, criminalizing substance use and removing encampments to investing in upstream efforts to tackle homelessness and mental illness, such as investments in affordable housing, therapeutic services, and living wage employment.

When asked about the crisis response system, Latin residents offered few perspectives related to the current crisis system. Instead, they wanted the city to address the root causes of homelessness such as affordable housing, economic opportunity and treatment options. When asked specifically about their experiences with the existing crisis system and the city's response to calls for service associated with homeless services, mental health, and substance abuse, a small number of respondents offered feedback on the existing crisis response system. Many responses

collapsed mental health, substance use, and homelessness and expressed frustration with the city's inability to identify and implement solutions. For those who did share personal experiences with the current crisis response system, there was a range of opinions about its effectiveness. Some respondents dealt only with the police during a mental health crisis and felt that they were professional and efficient while others expressed an unmet need for a counselor or clinician. A few respondents described positive regard for a collaborative team that includes the police and a mental health professional during crisis situations.

Overall, respondents focused on the need for long range solutions that prioritize early intervention, prevent crisis from occurring, and support people in achieving and maintaining sobriety, stability, and housing. They expressed frustration with what they see as a revolving door of people in and out of justice and mental health systems and called for strategies that effectively stop cycles of violence and recidivism, chronic homelessness, and drug abuse. When it comes to investments, respondents expressed diverse views. Some articulated growing frustration with the tax burden associated with program investments and believe that Berkeley attracts people from out of town struggling with homelessness, mental health issues, and substance abuse because of the city's tolerant attitudes and readily available supports. Others named the need to increase investments in long-term care facilities, treatment programs, therapeutic services, and job training.

Community lens on the Berkeley Police Department

Latin respondents expressed a wide range of perspectives regarding their overall satisfaction with the police with many expressing positive perceptions of the police. Many respondents held favorable views of the police and experienced positive interactions with BPD; they described the police as responsive, professional, effective, and supportive of community safety. Some respondents with favorable views of the police expressed a belief that the current political climate and movement to divest from policing does not represent the majority of residents' views. Additionally, respondents conveyed frustration with the city council who they characterized as a hindrance to effective policing. They believe that the BPD should focus on increasing community safety through crime prevention, intervention, and response. Some promoted a tough on crime perspective and expressed a belief that the BPD are mismanaged, over-controlled, and under-appreciated by city government. These respondents called for increased police presence, more investment in community policing, and proactive policing.

> *"The department needs to be supported by our community and allowed to do their jobs rather than being hamstrung by members of the city council…."*
>
> *—Resident*

Latin respondents who held unfavorable views of the police, cited slow response times, inability to prevent and solve crimes, and harassment of residents as the most salient features of the BPD.

> *"The police have stopped members of my family in West Berkeley in what was clearly racial profiling (Hispanics) on several occasions ."*
>
> *—Resident*

Respondents expressed concerns about racial profiling by the Berkeley Police and named it as a priority public safety issue. This sentiment was expressed by respondents supportive and unsupportive of the

police and was recognized as an issue that must be addressed by the Berkeley Police Department. Many respondents described specific instances of racial profiling and overly aggressive interactions between Black and Latin residents and the BPD. Although a few respondents called for divestment from the police department, the majority of respondents expressed an expectation for a high-functioning, service-oriented, police department responsive to the needs of communities of color and capable of equitable interactions. They recommended training on implicit bias, racial profiling, cultural competency, community policing, and de-escalation and expressed an unmet need for increased transparency, greater community engagement, and positive interactions between the police and communities.

Summary of Findings

Recommendations

The following recommendations represent a compilation of the focus group participants' ideas for improving public safety.

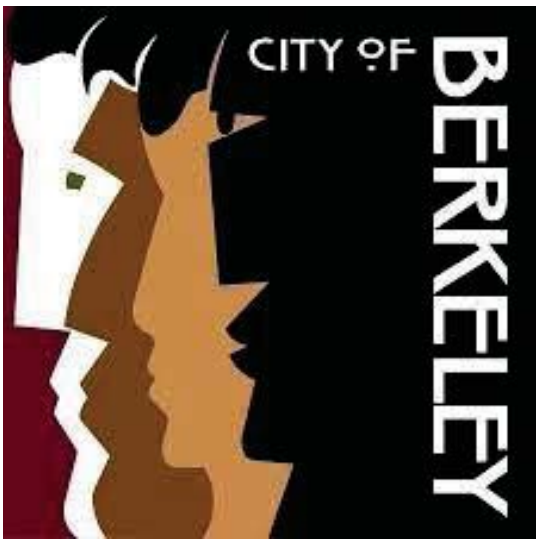
Key Recommendations

- Prioritize clean-up of streets and public parks
- Install additional lighting in neighborhoods
- Increase traffic control, create car free zones and areas where speed limits are reduced
- Focus on long-term planning to address homelessness
- Identify early intervention and prevention strategies to prevent mental health crisis and substance abuse issues
- Increase police visibility via walking and bicycle patrols

- Reduce police response times to calls for service
- Expand community policing initiatives and increase opportunities for positive engagement between the police and communities
- Address racial profiling and aggressive police encounters by the BPD with cultural competency, anti-bias, and de-escalation trainings and deepened relationships between the police and communities of color

CONCLUSION

The City of Berkeley and the Reimaging Public Safety Task Force are well-positioned to use their power and positionality to develop a community safety model that reflects the needs of the community, reduces inequities and disparities, and creates increased safety for all. This report summarizes the key findings from the Latin survey respondents' answers to open-ended questions and represents an important step in building understanding of community strengths, needs, and public safety priorities.



CITY OF BERKELEY:
REIMAGINING PUBLIC SAFETY—COMMUNITY PERCEPTIONS

Summary of Findings—July 2021

Bright Research Group
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BRIGHT RESEARCH GROUP

Introduction

The City of Berkeley is working to develop a community-safety model that reflects the needs of the community and creates increased safety for all. In collaboration with the National Institute for Criminal Justice Reform, Bright Research Group (BRG) facilitated a series of focus groups to gather community perspectives on the current state of public safety, the role of the Berkeley Police Department (BPD), and the future of public safety. The McGee Avenue Baptist Church; the Center for Food, Faith & Justice; and the Berkeley Underground Scholars facilitated outreach to Black, Latin, system-impacted, and unstably housed / food-insecure residents. This report summarizes the key findings from the focus groups conducted in the spring and summer of 2021.

Methodology

Bright Research Group worked with the National Institute for Criminal Justice Reform and the Berkeley City Manager s Office to identify several priority populations for community focus groups—Black, Latin, formerly incarcerated, and low-income individuals struggling with food and/or housing insecurity. The research aimed to gather community insights from those most impacted by disparate policing and was guided by the following research questions:

- How do community members view public safety in Berkeley? How safe do they feel in Berkeley, and what are their most pressing public-safety priorities?
- What ideas does the community have when it comes to reimagining public safety? How should public safety issues be addressed and by whom?
- How do community members experience and view the BPD? How does the BPD currently operate in communities, and what role should they play in future public safety efforts?

Data Collection and Analysis

Bright Research Group researchers conducted four focus groups and spoke with 55 individuals. The focus groups ran for 60–90 minutes and included questions about the participants' perceptions of public safety in Berkeley, including their opinions about existing and proposed responses to crime, mental health crises, homelessness, traffic safety, priorities as they relate to increasing public safety, and their experiences with and opinions about the role of the BPD.

Focus Group Description	Number of Participants
Black Residents	18
Housing- / Food-Insecure Residents	27
Black and Latin Youth	4
Justice-System-Impacted Students	6
Total Stakeholders	**55**

BRG analyzed the data from the focus groups and conducted a thematic analysis by research question. The themes uncovered during the thematic analyses are documented in this report as findings and recommendations, and they are intended to support the City of Berkeley and the Reimagining Public Safety Task Force as they work to develop a community safety model that reflects the needs of the community, creates increased safety for all, and reduces inequities and disparities about access to safety.

Limitations: The focus groups reached 55 individuals. A key limitation is that the qualitative data is not necessarily representative of the perspectives of Black, Latin, formerly incarcerated, and houseless residents. Additionally, youth under age 18 and Latin residents were not well-represented in the focus groups.

As part of the community-engagement process, BRG developed a community-safety survey that was distributed by the Berkeley City Manager's Office, the Reimagining Public Safety Task Force, and other community partners. As a group, focus group participants were more critical of the Berkeley Police Department than survey participants.

Findings

Community Perceptions and Priorities for Safety in Berkeley

When it comes to feelings of safety from crime, the focus group participants described Berkeley as a city divided. The focus group participants agreed that many areas of Berkeley are relatively safe but pointed to significant disparities in neighborhood safety. Black residents named the neighborhoods below Martin Luther King Boulevard as unsafe and the hills and neighborhoods above Martin Luther King Boulevard as safe. They indicated that feelings of safety for some come at the expense of younger adults, Black people, and unhoused residents, who are targets of greater surveillance and looming displacement. Black residents and students who participated in the focus groups emphasized that gentrification is detrimental to community safety, erodes community cohesion, and negatively impacts their sense of belonging in their own neighborhoods.

Focus group participants shared concerns about gang involvement, racism, and the availability of guns in Berkeley. Black residents expressed concerns about low-income Black youth s involvement in regional gang and group activity connected to Oakland and Richmond and described a need for deeper recognition of the vulnerability of Black youth. They called for increased investments in community-based and peer-led violence-prevention programs and named a specific need for Black-centered and Black-led mentorship interventions.

Black and Latin youth and students expressed significant concerns about their personal safety and worry most about being victims of robberies, shootings, and police violence. When asked about how safe Berkeley is, students and youth said they do not feel comfortable while walking the streets or enjoying public spaces in Berkeley and therefore move through the city cautiously. Black and Latin students and youth feel hyper visible while living in Berkeley. The students described feeling equally surveilled by neighbors and police and shared that living under a

> "A lot of people in our community don't feel safe around Black bodies and the reality is that there are less Black bodies in Berkeley That may be the plan from the perspective of those who don't feel safe around Black bodies..."
> —Resident

constant veil of suspicion is stressful, makes them feel like outsiders in their own city, and prevents them from fully engaging in the community. Black students pointed to the decreasing number of Black residents and the racism expressed by some locals as a source of stress. One Black student shared a story of being profiled by a neighbor who accused her of stealing packages from his porch.

In addition, the Black youth who participated in the focus group expressed dismay at the ease with which children and teenagers can purchase guns in the City of Berkeley. They spoke about a bustling, well-known, and easily accessible illegal gun market operating in the city and were troubled by the inability of the police and city leaders to stop the flow of guns into their communities. They named ending gun violence and police harassment of youth of color as Berkeley s most pressing community safety priorities.

The focus group participants lifted homelessness and the housing crisis as one of the most critical public safety issues in Berkeley; they feel strongly that the city is responsible for providing for the basic needs of every resident. The participants expressed dissatisfaction with the city s current management of homeless services and supports. When asked about the existing crisis system and the approach to homeless services, many of the participants explained that the police should have limited or no involvement in the issue. They cited the need to provide wraparound supports, including long-term housing, mental health care, drug treatment, and skills training for homeless residents. Residents across the focus groups believe that most crimes in Berkeley are crimes of survival or the result of mental health issues and asserted that building an infrastructure to support a higher quality of life for homeless and low-income residents would make Berkeley safer. They called for more investment in housing, health care, and youth programs.

> "It's not as safe as it used to be. It's too many people on the streets with severe mental health issues and nobody to monitor them."
>
> —Resident

During the focus group with housing-insecure residents, the participants shared their critiques of the current approach to public safety advanced by city leadership. From their perspective, the city leadership prioritizes investments that fulfill the demands of wealthy residents. As examples, they cited the installation of speed bumps on roadways and the placement of surveillance cameras on city streets, while the critical needs of homeless, low-income, and formerly incarcerated residents are ignored. They recommended 24-hour street teams to provide medical and mental health care in communities, safe indoor and outdoor public spaces that stay open late, more community-run drop-in programs with the capacity to meet their basic needs, and expanded access to education, job training, and healing arts.

The focus group participants rely on each other and community-based organizations for safety and support. Black residents, housing-insecure residents, and system-impacted students expressed significant distrust in the city government. When asked about who or what makes them feel safe in Berkeley, they emphasized that they do not feel seen, heard, or protected by government entities. Instead, they rely on one another and community-based organizations for safety and supports. At the same time, they have an expectation that the government should care about, work for, and be accountable to them as tax-paying and contributing residents of Berkeley. They were frustrated by what they see as the failure of city leaders to recognize their value, voice, and legitimacy when it comes to

influencing the way the city is run. They called for greater decision-making power when it comes to how resources are deployed in their communities.

Community lens on the Berkeley Police Department

The focus group participants do not view the BPD as* a community resource *and instead rely on themselves and their communities for safety. Black residents, youth, system-impacted students, and low-income residents experiencing housing/food insecurity agreed that the current practices of the BPD are not in alignment with the needs and priorities of their communities. When it comes to crime and violence, the focus group participants across the demographics indicated that officers are largely absent in their communities and questioned the police department s commitment, skill, and capacity to prevent, intervene in, and solve serious crimes.

Focus group participants believe that police resources are mismanaged. They explained that the police currently prioritize high-income residents' low-level calls for service and spend too much time enforcing quality-of-life issues and recommended that the city prioritize improvements in police response times to emergencies identified by residents, as well as building relationships with the communities who experience both the disparate impacts of policing and violence/crime.

When asked about their experiences with and perceptions of the BPD, the participants in the focus groups shared a common perception that policing in Berkeley is racist and classist. They said that they do not look to the BPD for protection and instead feel targeted and unsafe when in their presence. They asserted that the city leadership is complacent in the BPD's racism and allows racial profiling and the harassment of Black, brown, and low-income residents to go on unchecked in the city. Many long-time Black residents described an increasingly aggressive style of policing and militarization in recent years that stands in sharp contrast to the friendlier community policing style they experienced while growing up in Berkeley. Black men, women, and youth shared recent personal experiences of being racially profiled and stopped by the BPD and expressed feelings of anger about their experiences. Similarly, individuals struggling with housing insecurity reported being targeted by the police due to their race and income level. Two Latin students explained that they and their friends are often stopped on and near the campus by both the campus police and the BPD because they do not fit the profile of the average UC Berkeley student. In addition, the youth who participated in the focus group said they'd witnessed the police harassing homeless people and immigrants working as street vendors. In response, the Black, housing insecure, student, and youth participants attempt to avoid the police whenever possible.

> *"They {police} were people persons back in the day and now they are not. It was a different mentality."*
>
> *—Resident*

The focus group participants shared a range of perspectives regarding the future role of the BPD. Although they agree on the current state of policing in Berkeley, there are diverse opinions regarding the future role of the police. Some of the focus group participants believe the city should focus on police reform, while others think significant divestment from policing is needed. For those who discussed reforms, increased police training—including de-escalation, trauma-informed response, and racial-bias curriculum—were lifted as priorities along with a focus on hiring Black officers and officers of

color from the community to improve police-community relationships and increase trust. During the focus groups, Black participants, youth, and people experiencing food/housing insecurity lifted the importance of expanding community policing in the form of foot and bicycle patrols. In addition, residents named a need for increased police accountability in the form of mandatory body-worn-camera policies; community-led police commissions staffed with low-income people of color; the proactive, regular release of police performance and misconduct data; and swift terminations of officers who practice racially biased policing.

> *"The police are supposed to be superheroes who protect us, but they've turned against us."*
>
> *—Youth, age 13*

Youth recognized and named the power of the BPD and wish the police would use their power to protect them and support their communities. They would like to have police officers who are part of the community, live in the community, and interact positively with young people through sports and mentoring.

The focus group participants who discussed divesting from policing recommended that the city invest in trained peacekeepers and community safety patrols focused on crime prevention and intervention strategies. They lifted relationship building, cultural competency, de-escalation techniques, and restorative justice as the core strategies to be deployed by these community patrols.

Overall, the focus group participants believe that investing in community health and ensuring that all residents have equitable access to quality education, food, shelter, and jobs should be the priority over investments in and reliance on the police to create community safety.

Community Ideas about Alternative Responses

When it comes to mental health crises and homelessness, the focus group participants across the demographic groups suggested that clinicians and social workers play a role in interventions and responses. While most of the focus group participants characterized the police as not fit or qualified to respond to these calls and wanted police response limited to situations involving violence, they described an expectation that when police do respond, they are skilled in crisis intervention, de-escalation, and cultural competency.

> *"They need more street teams; they drive around looking for tents and sign people up for services. Back then there used to be street teams, but now there's not as many. They need mental health teams, not the police"*
>
> *—Resident*

> *"Police ask if they can search the car, if you are on probation or parole, and if there are any drugs or guns in the car before they even tell the driver why they were pulled over."*
>
> *—Resident*

The focus group participants across the demographic groups viewed traffic enforcement as a low- priority public safety issue in Berkeley. They recommended that the role of the police be streamlined and believe that officers currently spend too much time involved in car stops, which disparately target Black residents. When presented with the idea of unarmed staff handling traffic enforcement, most were open to the idea, but some expressed concerns about the safety of civilian staff. Although Black residents expressed support for non-police responses, they have little confidence in the city s ability to decrease racism and disparate stops through the creation of unarmed civilian units.

The Black residents who participated in the focus group do not trust that the city s proposed alternative programs will reduce racial oppression and racial disparities*,* noting that the racism and anti-blackness that exists within the police department exists throughout the city government. They feared that without a true commitment to an antiracist approach to program design and implementation, as well as an authentic process to co-create these programs with the most impacted communities, the new programs will simply replicate the racist abuse, oversurveillance, and lack of responsiveness to community needs currently practiced by the police department. They explained that hiring local Black social workers, mental health clinicians, and traffic-enforcement staff will be essential to ensuring equitable interactions between Black residents and any new programs or city departments.

Community-Centered Vision of Public Safety

The focus group participants shared a common vision of public safety beyond the absence of crime as the presence of community health and equitable access to a higher quality of life for low-income, homeless, and Black and brown residents. The focus group participants expressed hope in the future of Berkeley and a desire to build close-knit, inclusive communities capable of taking care of all residents. Across the focus groups, the residents called for the city to make long-term investments in housing, educational enrichment, mentoring, health care, and job-training programs for youth and low-income residents. These, they maintained, would create authentic community safety. Other investment priorities include drug-treatment services, programs to interrupt recidivism, and prevention and advocacy to address gender-based violence and intimate-partner abuse.

Black residents expressed willingness to work collaboratively with the City of Berkeley and the BPD on relationship building, reform, and reimagining efforts, but in the meantime, they named a need for safety ambassadors who can act as a bridge between the Black community and the police. They expressed frustration about what they see as the city government's failure to listen to and act on their experiences and expertise when it comes to designing public safety strategies. Black residents believe they have a lot to offer when it comes to creating and implementing new programs and strategies and see their involvement in reimagining efforts as essential to increasing equity, reducing harms, and increasing safety.

The focus group participants expressed broad support for and belief in the power of community-driven crime prevention strategies and expressed trust in community-based and faith-based organizations. They believe the city government should make deeper investments in the community-based organizations run by leaders of color from the community. In addition, marginalized communities want increased access to power in the city in the form of representation. They explained that seeing more Black, Latin, and people from low-income backgrounds who share similar experiences in city-leadership positions, on committees, and within the police department will make Berkeley a safer city.

Summary of Findings

Recommendations

The following recommendations represent a compilation of the focus group participants' ideas for improving public safety.

Key Recommendations

- Expand the city's definition of public safety to include community health and equity
- Prioritize long-term investments in housing, mental health care, and drug treatment for homeless residents
- Increase investments in community-based and peer-led crime prevention programs
- Create 24-hour street teams to provide medical and mental health care in communities
- Invest in community-based drop-in centers
- Train community peacekeepers and create community safety patrols
- Hire local Black social workers, mental health clinicians, and traffic-enforcement staff to support equitable interactions between Black residents and any new public safety programs
- Streamline the role of the police to focus on violence prevention and intervention and responses to emergency calls for service
- Increase transparency and accountability of the BPD regarding racially disparate policing
- Increase opportunities for positive police engagement with Black and Latin community members and youth
- Identify opportunities to partner with impacted communities on reimagining public safety strategies

- Prioritize the representation of Black, Latin, youth, and criminal-justice-impacted individuals, as well as people who've experienced homelessness, in city leadership, police-department staffing, and committee appointments

CONCLUSION

The City of Berkeley and the Reimaging Public Safety Task Force are well-positioned to use their power and positionality to develop a community safety model that reflects the needs of the community, reduces inequities and disparities, and creates increased safety for all. This report summarizes the key findings from the focus groups conducted in the spring and summer of 2021 and represents an important step in building understanding of community strengths, needs, and public safety priorities.

NICJR
National Institute for Criminal Justice Reform

Reimagining Public Safety
Berkeley Merchants Association Listening Session

NICJR facilitated a Listening Session with the Berkeley Downtown Merchants' Association and the Telegraph Merchants' Association on June 2, 2021. Thirteen people attended the listening session. Following closely to the guidelines defined by BRG, the facilitators engaged in a robust discussion with participants. Below are summary findings from the Listening Session:

Concerns over the Safety of Berkeley and the most pressing public safety issues:

Participants shared concerns over the safety of the City, the most pressing concerns their employees and patrons face, as well as their perceptions on how these concerns are being addressed. They expressed their disheartening perception that the city council and mayor are less than responsive to the needs of the business community and have allowed a permissive environment that creates the opportunity for crime to take place with an "apathetic enforcement policy". Some participants feel as though businesses deal with a lot of problematic street behavior with ambassador staff regularly called upon to respond to situations where merchants and shopkeepers can't deal with the situations. Sharing specific stories of people experiencing homelessness and/or substance use addiction attacking employees and customers and creating unsafe and unhealthy conditions, participants feel that the current environment has definitely had an impact on people who visit local businesses because they have to park around the corner, and walk to businesses.

"It does not feel safe especially during the later hours of the day."

Addressing how these public safety issues should be approached:

Participants feel there is a contradiction in saying that we stand united against hate and we are reimagining public safety and allow people to smoke crystal methamphetamine on our streets. There is a fear that with continued acceptance of specific drugs being used on the streets that the incidents of people experiencing mental health breakdowns will increase and that a stronger use of punishment to deter this behavior is warranted. Some participants expressed the need for there to be a choice: we can choose to allow those drugs to be used and then we can expect more violence or we can actually take a stand against that.

Additionally, members of the business association feel that prevention is what's going to shift the environment. They recognize that the City of Berkeley has mental health services but feel they are really not getting support from the city, when they have seen the mobile crisis unit

drive away from a situation because it was deemed that no one was an immediate danger to themselves or others. There is a perception that there is no follow through with identifying a person with a problem and then going forward with next steps.

"We need to focus on Berkeley Mental Health as an institution and get them more deeply involved with the police department and the community."

Community investments that would support increased public safety:

The participants engaged in a discussion around the complexity and depth of the issues that need to be addressed, for example, where do those experiencing homelessness go? At the same time, there is an acknowledgement that businesses are seeing a drop in patrons and employees because of safety concerns.

In response to questions regarding a trained, alternative, civilian response that was trained to be able to engage with this population and might include people who have had similar experiences of being unhoused, the Berkeley Mental Health department was identified as already available, but having been less visible downtown, limited in their ability to take valuable, sustainable steps to help someone in crisis unless there is a direct and immediate threat of harm and/or unsupported by the city in recent years. A participant identified the call center now under construction near a local synagogue and expressed the desire to see the community do more of that type of thing. A suggestion was also made that the City should look into a policy that can allow the mental health units to take more initiative.

Addressing the ways in which the Berkeley Police Department currently works in the community:

A general sentiment was that merchant interactions with the police have been very positive, yet there is often a hesitation to call on them for concern over unnecessarily escalating a situation. Concern was expressed that there is a national narrative demoralizing police departments as a whole and police departments are not given the tools they need to do their jobs. In Berkeley it was expressed that there was a shift in the amount of police presence and response in the community and that police officers were told by the City to not do anything.

In addressing some areas where the Berkeley Police Department's presence has been particularly effective, the bike detail was mentioned with the sentiment that this unit is about community policing and they get to know the street population and merchants which is helpful in problem solving and helping people. The Ambassador program was also identified as a unit that is helpful in de-escalating individuals in crisis, and working well in collaboration when police officers are present. With the CAHOOTS model and the SCU - the biggest issue participants feel the City faces is beds and how to get people into care 'with a little bit of tough love'. The possibility was raised of mental health professionals and police officers working together when responding to a situation.

"I have great support for what the bike detail is doing since they have been back on the force. They have a calming effect for a lot of the folks out there that get a little wild, actually seeing a person in a position of authority calms them down."

BerkDOT and SCU Program Opportunities:

There was a desire to learn more about exactly how these programs would be able to best serve the community with the current policies in place. Additional concern was expressed with the national narrative and how the City of Berkeley needs to ensure that whatever changes are being made, need to address the specific issues and needs facing the residents of Berkeley. With respect to the BerkDOT program a participant shared: "I don't understand why that was even thought of. It just seems like we are focusing energy away from the problem, which is the fact that we have a ginormous mental health, drug, and homelessness problem in Berkeley. I do not agree that adding that additional agency would help the problem."
For the SCU, the specific need for case management and a presence in the community later at night was discussed. An overlap with the Police Department to partner with mental health workers in responding to situations and help assess whether SCU is reducing the number of calls and can cut back on the overload of the work of the Police Department. A suggestion was made for the SCU to work with both the Downtown and Telegraph Business Associations to identify the handful of folks that are causing a majority of the problems.

"Until we enforce our sidewalk ordinances, until we make people go to sanctioned encampments, stop the revolving door of violent crime and until we stop the hard drug use and open-air Drug Market this is an absolute waste of your time and our tax dollars. Prevention first."

<u>Visioning community-centered public safety</u>:

Considering what public safety can and should look like, a question was raised asking for better use of vacant space to set up housing and full services that could be helpful for as many Berkeley residents as possible. It was expressed that Berkeley has an abundance of laws and ordinances currently that don't get enforced, which is helping to create the unsafe environment that exists. Therefore compiling new variables instead of using existing laws to address the foundational issues did not sound like a good idea. There was frustration that participants themselves have invested hundreds of hours into issues of public safety and nothing ever gets done.

"If you look at the relationship between what we pay in taxes and regulations and everything else versus what we get back, the disparity is anything but equitable and people love to throw the word Equity around in Berkeley."

PEERS LISTENING SESSION REPORT

by Janavi Dhyani and Margaret Fine[1]

The Peers[2] Listening Session raised fundamental questions about how people who live with mental health challenges experience and perceive "safety" in the Berkeley community.

Throughout the Peers Listening Session the participants described their notions of "safety" in terms of their own safety; the safety of people who they observed in the community living with mental health challenges; their "safety" as a collective group of people in the "Peers community;"[3] and "public safety" at-large as a pressing societal issue such homelessness.[4] The participants spoke about their interactions and perceptions of Berkeley police, and how that impacts their feelings of "safety" in their community as Peers. Primarily they expressed their fears, based on lived experiences, interacting with police during a mental health crisis[5] in the community, and how a policing response generally had a negative impact on their ability to feel "safe" in Berkeley. Peers offered several recommendations about how they would like to experience "safety" including increasing their involvement as responders to mental health crises. It is noteworthy that additional research with Peers would be highly useful to account for the role of race, ethnicity, gender identity and expression, sexual orientation, disability, age, class and other factors, and their impact on a policing response to a mental health crisis.

Additionally during this Listening Session participants expressed the need for police to acknowledge when they are "wrong" in their treatment of Peers, particularly for purposes

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[2] A **Peer** is a person who self-identifies with lived experience with mental health challenges, substance use experience, and/or someone with experience navigating the public behavioral health care system.

[3] The **Peer Community** is composed of diverse people who use their lived experience with mental health challenges, substance use experience, housing challenges, and/or navigation of the public behavioral health care system to increase peer-led support and services for people in the mental health community. The Peer Community is also active in de-stigmatizing mental health challenges, and normalizing wellness and recovery.

[4] For the purposes of this report, **homelessness** is defined as housing insecurity ranging from being at risk of losing housing, being in transition of unstable housing (i.e. staying temporarily in a housed location like a friend's house or shelter, but not maintaining a personal address), or living in a location not intended to house humans (i.e. a car, an underpass, or in a tent).

[5] A mental health crisis is an umbrella term that may refer to: 1) different levels of personal distress such as anxiety, depression, anger, panic and hopelessness; 2) changes in functioning including neglect of personal hygiene, unusual behavior; and/or 3) life events which disrupt personal relationships, support systems, living arrangements, and result in victimization and loss of autonomy.

of establishing trust and rapport with the overall Peers community. Moreover, when discussing a non-police crisis response through a Specialized Care Unit (SCU) to non-violent events in the community, one participant said they "like the idea but it takes the onus off the cops to do better" and that it "still feels troubling, seems like a Band-Aid," as opposed to addressing systemic mistreatment by police of people living with mental health challenges and overall within the Peers community. Based on the lived experiences expressed during this Listening Session, it is indicated there is a need for a reconciliation process, particularly as a response to traumatic experiences with police. A reconciliation process, as well as a restorative justice process, with people living with mental health challenges may help build trust and rapport with police officers in the future.

It is also important to recognize that the Public Safety Dispatch Operators in the Communications Center located at the Berkeley Police Department address emergency and non-emergency dispatch calls for service, including for people experiencing a mental health crisis in the community. It is understood that police act on their own accord responding to these crises in Berkeley; some police have CIT training (Crisis Intervention Training) and in some instances police co-respond with the Mobile Crisis Team (MCT) of the Division of Mental Health to assist people experiencing a mental health crisis in the community. The MCT currently operates in Berkeley for 10.5 hours/day, 5 days/week, excluding holidays (see City of Berkeley, MCT webpage). In the systems currently in place, it appears protocol mandates that police first secure the scene before an MCT clinician can step up and support the person experiencing a crisis (including to interact with an individual experiencing an "altered state of consciousness").[6] Please kindly inform if incorrect. It is noted that the Fire Department, including an EMT, may also respond to mental health crises in the community with other first responders or on their own accord.

In addition, there were participants at the Listening Session who have used emergency services to address a person experiencing a mental health crisis, saying that "I've had to call the police on people with mental health issues and it broke my heart and that is something I would not like to do." Indicating that folks did not feel proud of their decision to call emergency services, knowing that police would arrive, but did so because they did not feel like they had alternative options to provide that person with appropriate support.

There is a need for clarification about how Public Dispatch Operators and the police use their discretion to make decisions about "public safety threats." It is not clear if the current protocol is designed to not only determine if someone is a "danger to themselves or others," or "gravely disabled" to meet the standard for a 5150[7] involuntary hold, and/or if

[6] An altered state of consciousness may be defined as a temporary change in the overall pattern of subjective experience, such that the individual believes that his or her mental functioning is distinctly different from certain general norms for normal waking state of consciousness.

[7] In the State of California, a 5150 is "when a person, as a result of a mental health disorder, is a danger to self or others, or gravely disabled, a peace officer, professional person in charge of a facility designated by the county for evaluation and treatment, member of the attending staff, as defined by regulation, of a facility

the assessment offers a more nuanced evaluation for persons who do not meet this standard, particularly to assist with next steps in care if needed. There is a need for people with mental health challenges to provide nuanced input about their perceptions and experiences in this context, particularly given that a "crisis" can be used as an umbrella term for diverse array of human behavior; and the role of race, ethnicity, gender identity and expression, sex, sexual orientation, disability, age, class and their intersections can impact the nature of a policing or co-responder crisis response in the community.

Further participants talked about their own lived experiences with police during a time of crisis and whether they felt "safe," as well as their overall perceptions and feelings about them. Specifically, the main emerging themes included their perceptions and experiences about: 1) officers unease connecting with people experiencing a mental health crisis; 2) feeling stigmatized as dangerous and regarded so by officers; 3) the role of de-escalation if any; 4) feeling traumatized or re-traumatized by police during a mental health crisis; and 5) recommendations to improve mental health crisis response in Berkeley. At the outset it is noted one participant felt treated "pretty good" by police despite run-ins over four years. Another participant talked about witnessing the police when someone was lying on the ground. He described how the police, fire, and ambulance showed up, "asked the person do they know where they are, asked them a variety of questions, stayed there with them, and even seen them give them a blanket before." However among many experiences and perceptions described during the Peers Listening Session, these experiences were outliers.

Section 1: Peers and Mental Health Crisis Response

I. ***"Really important to speak their own language"—participant***

Peers indicated the importance of understanding and empathy during a crisis.

During the Peers Listening Session some participants raised questions about how police approach them and/or other Peers in the community. They discussed their perceptions and feelings about being seen as "public safety threats;" and generally as something to be controlled rather than human beings who need emotional "safety" to resolve their crisis. In particular, the participants expressed their fears of being met with police violence instead of with compassion and empathy for their plights. The notion of "safety" ranged from people feeling exceedingly vulnerable and "unsafe" while experiencing a mental health crisis in the community to a wide variety of crisis responses (based on actions, words, physical harm, and/or lack of response/over response) by police to them. Overall participants mentioned that most people experiencing a mental health crisis are not violent.

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designated by the county for evaluation and treatment, designated members of a mobile crisis team, or professional person designated by the county may, upon probable cause, take, or cause to be taken, the person into custody for a period of up to 72 hours for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment in a facility designated by the county for evaluation and treatment and approved by the State Department of Health Care Services. See WIC 5150(a).

Consequently, it is critical to further explore how Peers would describe developing a human connection, and develop trust and rapport, with a distressed person in terms of defusing a situation. People living with mental health challenges may experience a non-threatening altered state of consciousness and the police presence may exacerbate the intensity of their situation. Instead, Peers indicated that it would be more effective to make a human connection with the distressed person and de-escalate the situation so they felt "safe." Moreover, public safety dispatch operators and police officers may not be trained to understand the intersecting challenges and systems that may be contributing to and/or exacerbating the Peer in crisis and the mental health community as a group.

Specifically, one participant commented that Berkeley police are "not ready to deal with people who are upset with emotional disturbances," and that people in crisis "don't need violence when people are angry" to resolve their crisis. Another participant felt the police "get scared of mental health" and said they "need to not be afraid of people, people who are eccentric." This participant spoke to the stigmatization of the Peers Community, and the need for additional training and public education about how to interact with community members who interact with the world differently than they do. Peers indicated the need to further explore the types of human behaviors that meet the 5150 standards and/or constitute criminal behavior, as opposed to other behaviors that may not fall within social norms but do not pose a threat to the public.

A second participant expressed concern that "some cops [do] not feel safe…don't speak a whole lot." She commented about feeling "really uneasy" when you need "someone to talk more, like hostage negotiator, convey sort of friendship and comradery." She discussed seeing someone "high energy, manic, talking real fast, as an opportunity for person in the crisis to grow rather than shut down with drugs, incarceration, hospitalization," and stated, "we need to learn, develop a field of knowledge of people in altered states." This participant alluded to a common understanding in the Peers Community that mental health crises can bring about positive change for the person involved and should be allowed to occur in a safe setting when possible. There is a need to further explore perceptions and experiences of people living with mental health challenges to better understand the nature of stigmatization, and how it impacts a policing and mobile crisis response, especially when addressing intersecting identities of Peers based on race, ethnicity, gender identity and expression, sexual orientation, disability, age, class, and other factors.

This same participant attributed the lack of human connection exhibited by police with people experiencing a mental health crisis "as most cops [are] not trained that way." The participant went on to say that police officers "use major tool like [a] gun and bullets; something startles them, go for the gun." The point was further underscored by another participant, who stated based on their experience with police, "that it is always with guns; it's a threat, always a threat of violence out there, police come with their guns," and that we are "much better served with people not heavily armed, I don't know how, I think the

conversation and non-violent tactics." It is noted that the lack of Peer involvement in the training of police officers, and the resistance to use Peers in the response to mental health crises, can inhibit responders from understanding how Peers would like to experience "safety" in a time of crisis.

Participants talked about the lack of Peers in crisis response, that Peers have been left out of the conversation, and that for crisis response to improve, trained Peer Specialists[8] need to be involved. This perspective became clearer when talking about the Specialized Care Unit (SCU) program that Berkeley will be implementing as a non-police crisis response in the community. Everybody in the group generally liked the idea of non-police responders to non-violent calls, however, with two exceptions: 1) one person named that without retraining police officers, police would still respond in public with the ability to cause harm; and 2) that Peers would feel safer if the SCU team included Peers. The importance of Peer staffing on the SCU team was highlighted by different participants.

> ***"Facilitator: Who do you think should do the training for the SCU?***
>
> ***Participant 1: Someone with lived experience.***
>
> ***Participant 2: I agree.***
>
> ***Participant 3: I agree. I totally agree."***

During the Listening Session, it became clear that the Peer participants could clearly identify that it was important for the crisis response training to include people who have lived experiences alongside other first responders as a team. Another participant explained the importance of peer specialists for training by saying, ***"What better person can teach them how to respond, body language, than someone who is on the other end and who has walked the walk, and already been through it."*** The participants seemed to be in agreement that one Peer could not respond to crisis situations alone, but was an essential part of the team in both training and in-person response situations. Moreover, participants underscored the importance of Peer-involvement in ongoing post-crisis support to "***Make***

[8] A Peer Support Specialist is a peer (a person who draws on lived experience with mental illness and/or substance use experience and recovery) who has completed a specialized training to deliver valuable support services in a mental health and/or substance use setting and/or in the community. According to the Peer Certification Fact Sheet from Senator Jim Bael on SB 803: "Studies demonstrate that use of peer support specialists in a comprehensive mental health or substance disorder treatment program helps reduce client hospitalizations, improve client functioning, increase client satisfaction, alleviate depression and other symptoms, and diversify the mental health workforce. " As of SB 803 Peer Support Specialist Certification Act of 2020, Peer Support Specialists in the State of California will have a standardized certified body to regulate and certify Peer Support Specialists. SB 803 will allow Peer Support Specialists to bill Medi-Cal for the services they offer to their peer partners in the State of California. With SB 803 California will join 48 other states in the country that have peer certification programs as part of their Medicaid behavioral health network.
https://namisantaclara.org/wp-content/uploads/2020/09/SB_803_Beall_Peer_Certification_2020_Fact_Sheet.pdf
https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB803

sure there is continuity of care" and pointed out that "***The peer specialists are helpful for transition to a wellness center or the next social service.***" This continuum of care would include: wrap-around services and support in navigating the intersecting and often complicated systems of care (i.e. housing, public benefits [SSI, SSDI, SNAP, GA, Medi-Cal, Medicare]; disability; health, mental health, and substance use support; meal assistance; support groups; drop-in services; community programming; employment support). There is a need for further input from people living with mental health challenges about the community-based services they use in Berkeley and Alameda County, particularly ones considered to be compassionate and effective in providing tailored culturally safe and responsive services.

II. "When I see police, it can be triggering, it can be negative, not friendly" – participant
Peers indicated a history of mistrust towards police officers.

In addition, there were emerging themes about how people living with mental health challenges have experienced police as threatening, which may perpetuate and reinforce trauma in responding to mental health crises. One participant stated that "many people have negative feelings on police" and when they see police "it can be triggering, it can be negative, not friendly, open." Another participant "witnessed police in action in Berkeley," and said they did not want police on mental health calls, as they were traumatized to the point of seeing police in a "whole different light." Yet another participant stated that "So many of us have been harmed when we are treated when we are in crisis" and mentioned Soteria House, a community service that provides space for people experiencing mental distress or crisis, as a recovery model. Other participants also discussed how drop-in centers can offer this space, provide a restroom, a cup of coffee, and a welcoming space in which the person can get their basic life needs met and make meaningful connections with other Peers. Peers indicated that distress could be better met by safe spaces in which a person is allowed to move through the emotions they are feeling without fear of judgment, retaliation, or incarceration while being met with basic life needs (food, water, bathroom, a sense of safety, and human connection). There is an essential need to explore how a Peer can feel "safe" transitioning from experiencing a crisis in the community to a respite space with the support of a Peer specialist and other responders, as opposed to feeling treated as dangerous and in need of social control and being subdued.

Participants further talked about how the presence of police could exacerbate the intensity of personal distress and create feelings of extreme terror and instant fear of extinction, as opposed to creating ones of emotional "safety." While the participant did not describe the basis for officers' arriving at the scene, he described his feelings about a police response by stating "it is multiple police cruisers, you feel like the world out to get you and annihilate you, officers are intimidating, 3-4 cruisers with multiple cops, very, very troubling and high-risk situation." This feeling of being responded *to*, instead of being met *with*, is a sentiment

people shared. One participant said that "If someone is having a mental health crisis, sit **with** them and let them be." Peers indicated that they are not "safety threats" that need to be responded *to,* rather they are humans that need to be met and supported *with* and *through* a situation they are not able to safely endure alone. It would be beneficial to further understand when Peers perceive their own behavior as threatening and how they expect first responders to interact with them as a result.

III. **Policing and mental health crisis response**

During the Listening Session, it was clearly conveyed by the majority of the participants that police officers should not be the first responders to mental health crises. When asked what situations police would be able to respond to appropriately, the Peer participants discussed when they would feel police intervention may be necessary. Overall there was a range of different perspectives about the role of the police officers in the mental health community. Initially, Peers felt police officers need specific training for crisis response. One participant questioned the amount of de-escalation training that police receive as he regarded it as the "major pain point" in defusing a mental health crisis. In this light, another participant asked about situations where a person may have a weapon and the type of response to them. Another participant indicated having a mental health person upfront and police shadowing if needed. A fourth participant stated he would want police if his car was burglarized, but he wants a skilled person with lived experience to respond and police second to ensure safety if needed. This area deserves considerably more exploration about the nature of situations where people with mental health challenges may feel police need to respond. Generally, participants suggested that there may be different people and/or teams responding depending on the type of situation. There is a further need to explore the nuances of specific situations among people living with mental health challenges in order to better understand from Peers when they perceive certain types of teams responding to a mental health crisis in the community. Moreover, there is a need for Peers to discuss their lived experiences and perceptions of crisis response; the role of race, ethnicity, gender identity and expression, sexual orientation, disability, class, and age; and its impacts on police response to those living with mental health challenges.

IV. ***De-escalation is the "Major Pain Point"—participant***

Further research is needed with people who live with mental health challenges, including the PEERS community for understanding peer-informed/peer-created de-escalation practices.

There is a critical need to have a nuanced understanding about how people with lived experience of the mental health crisis in the community describe levels of personal distress such as anxiety, depression, anger, panic, and hopelessness and how to meet their needs for "safety," as well as how changes in basic functioning can impact the capacity to stay "safe" and not be a danger to themselves or others, or deemed gravely disabled—the 5150

involuntary hold standard in California. Depending on the type of crisis response provided to individuals experiencing distress, the physical and psychological impacts on "safety" may vary widely. They can range from de-escalating crises using specific mental health practices to using coercive controls and force to restrain individuals in crisis. In the latter circumstance, an individual may be restrained, arrested, taken into custody, transported, put in secure detention and there may be violence, brutality, or even death. It is critical to extending this research in order to clarify the levels and types of personal distress, and how they impact functioning according to Peers who are living with mental health challenges, and the types of crisis response that work for them in the community.

There is a specific critical need to explore the degree to which police approach a distressed person and defuse the situation versus using coercion, particularly during 5150 assessments. Both commissioned consultants, National Institute for Criminal Justice Reform and Research Development Associates, should account for the role of police and policing interactions when conducting research with people experiencing mental health challenges and providers, particularly to understand how people can work collaboratively with providers in order to facilitate productive relationships. Whether the research focuses on police interactions with people experiencing mental health challenges in the community on their own accord or when corresponding with the Mobile Crisis Team of the Division of Mental Health, police play a significant role and impact the nature of crisis response. Without this key data, the consultant researchers will be gathering unrepresentative pieces about a comprehensive crisis response system that operates at all times with the police. Moreover, people living with mental health challenges may have lives that interplay among multiple systems, including policing and mobile crisis response systems, and it is critical to understand the overarching impacts and how to support their well-being and recovery.

During the Peers Listening Session, participants had overriding concerns about police choosing to use violence and guns as a first resort during a mental health crisis in the Berkeley community and not communication and non-violent tactics to de-escalate the situation. It is further important to gather data about policing behavior and accountability during Mobile Crisis Team calls. Gathering this data is essential to the Reimagining Public Safety Initiative and the Specialized Care Unit for the City of Berkeley and the overlap among systems means we need to include not only these inherently critical pieces but analysis about how the systems interplay and impact people living with mental health challenges and their well-being and recovery.

Overall crisis response to people experiencing mental health challenges in the community requires a commitment to conducting empirical research that is nuanced so we understand the complexities required to properly serve and protect all of our community members. It is clearly evident that the role of police during a mental health crisis is a turning point for people with mental health challenges in the community and we must thoroughly understand the nature of their police behavior in order to begin healing. It is further

important again for people with lived experience of mental health challenges to have restorative justice and reconciliation processes to describe events such as police responses to their crisis and how they can disrupt relationships, social networks and communities, living arrangements, and other mainstays of personal life, as well as to understand when a police crisis response is necessitated for "public safety" reasons in the Berkeley community.

Section 2: Peers and Homelessness

Several participants considered "homelessness" as one of the most pressing public safety issues both in Berkeley and generally. Participants shared their perspectives based on: 1) lived experiences of homelessness in the past; 2) living as a housed person with unhoused neighbors and/or 3) being Peer advocates for partners with housing challenges. One person saw the homeless conditions such as lack of safe water, toilets, rodents and other problems impacting both those housed and homeless. She had mixed feelings about the encampments, particularly given the chaos and havoc at night. Another participant talked about how he "enjoyed living on fringe of society without any accountability, really free, [but said] looking back, I was really incarcerated." He is now housed.

Generally the participants felt it was "unsafe" to be homeless and even harder for people living with mental health challenges. For people living with mental health challenges and homelessness, one participant described their difficulties: "the ones that have had problems, have gone through what they have gone through, makes [it] harder to want to be in a home…." Another participant further talked about the intricate nature of homelessness, and the intersectional approach necessary to meet the needs of unhoused folks. He was someone who experienced homelessness, as well as mental health and substance use challenges. This participant clarified how organizations may offer a free shower and food to "clean people up;" but are not designed to house people (using a Housing First model); provide wrap-around services; or job training for work.

A third participant talked about how homelessness does not "build healthy [a] community" as you're "living where you shouldn't really live," while another pointed to issues like "deprivation and exhaustion that these poor people go through." Potentially further research with people living with mental health and housing challenges could inform how homelessness impacts the nature of people's mental health challenges, and the type of services needed—one person suggested crisis management and conflict resolution. Another person had sympathy for folks' experiences of homelessness and having their possessions thrown away. Participants generally described the grinding efforts needed to survive, including constantly dealing with lack of necessities and fear of having their household belongings abruptly discarded.

In addition another participant talked about one of the driving forces of homelessness being the increase of housing prices in Berkeley, saying “gentrification and homelessness...Some people can’t afford to live in a home on their own.” This participant indicated that homelessness is not a challenge that can be met by services alone, but that economic disparity continues to play a role in people becoming unhoused. Another participant echoed this comment by saying, “most homeless people not [the] problem, situation drives it, it’s an economic thing.” He indicated that homelessness cannot be met with social services, but needs to also look at through an economics-informed lens.

A few participants discussed other services that were offered in San Francisco that they did not believe are currently available in the City of Berkeley. One participant liked that “In San Francisco they are doing foot patrol” and indicated it would be helpful to have people who provide services going directly to the unhoused in their community too. Another participant mentioned that in San Francisco “they have peers in the library” and said they liked that idea and that Berkeley might also benefit from having Peers in public spaces where unhoused people congregate. More about San Francisco’s street crisis response, that the participants may have been indicating, can be found here: https://sfmayor.org/article/san-franciscos-new-street-crisis-response-team-launches-today

It is important to indicate that further research is needed with the unhoused population to understand the intersecting nature of mental health and substance use challenges and homelessness, particularly to explore the nature of policing and crisis response and whether the systemic responses are service-oriented and/or designed to stigmatize and criminal human behavior or both. It is also important to further understand this intersectional approach as including exploration about the role of race, ethnicity, gender identity, and expression, sexual orientation, disability, age, class, and potentially other factors.

Although it is indicated that further research is recommended, the Peers Listening session did provide considerable insight on the intersection between mental health challenges and homelessness. The majority of the participants agreed that the most important pressing public safety concern is homelessness. One participant pointed out that “mental health crisis[es] and homelessness are synonymous,” and as such should not be treated as completely independent challenges. Within the challenge of housing insecurity, several other sub-concerns were addressed including: (1) the lack of intervention by systems of safety in Berkeley; (2) economic disparity and increasing housing prices driving long-time residents out of their homes; (3) lack of wrap-around services, and systems of care addressing challenges in isolation instead of as addressing homelessness as a product of other underlying challenges, which are often intersecting and multi-dimensional.

Peers Recommendations

1. The first and most important recommendation is to outreach and includes Peers who have worked on mental health reforms since the 1990s, when this movement began. There are trained Peers in Berkeley who are experts in crisis response, and they would be invaluable to developing responses to mental health crises and supporting the transition to new systems of safety in Berkeley. This role is, especially, crucial for unpacking the scope and nature of mental health crises to provide a nuanced understanding, approach, and framework for responding with appropriate levels of care to people with mental health challenges in the community--particularly for a non-police crisis response through a Specialized Care Unit. Peer participants discussed the San Francisco Crisis Response Street Team, and how this city is employing Peer Specialists on foot patrol as part of its team.

2. Drop-in and wellness centers for people living with mental health challenges need sufficient funding and staff with full-time Peer Support Specialists where folks experiencing non-threatening altered states and/or mental health crises can move through their crisis is a safe and supported state (in opposition to tactics which aim to shutdown mental health and/or altered states at any means necessary). It would be essential to make drop-in and wellness centers available 24/7 and on holidays, and to make sure there are also Peers involved in the transit from the mental health crisis to the Peer staffed drop-in/wellness center. Peer navigators are also key to assisting people in navigating complex systems, including how to get appropriate services in the City of Berkeley and Alameda County.

3. There is a need to account for intersectionality and the role of race, ethnicity, gender identity and expression, sexual orientation, disability, age, class and other factors that can impact the scope and nature of crisis response for diverse people living with mental health challenges in the community. It is, particularly, important to address the stigmatization of diverse people living with mental health challenges and how the role of these additional demographic characteristics may or may not perpetuate and/reinforce problems during a mental health crisis (including as to the roles of people such as police, fire, mental health clinicians, peer specialists responding in the community). There is a specific need to focus on interviewing diverse people with mental health challenges who are unhoused in order to explore the nature of policing and systemic responses to people, particularly to examine if human behavior is criminalized and/or met with service delivery.

4. There is a further need to account for overlapping systems of care, including medical, mental health, substance use, social services and other systems. Participants in the Peers Listening Session, who identify with homelessness,

discussed how current systems are not set up in a way that enables long-term sustainable wellness of the mental health community. Housing-first methods, for instance, are only successful in addressing homelessness if the other factors that contribute to housing insecurity are also addressed such as mental health and substance use services. Overall creating comprehensive wrap-around services may be the key to addressing public safety concerns. Moreover, including people with lived experiences of mental health, substance use, and homelessness will enable systems to be consumer-informed, and in turn more sustainable in the long term.

5. There is a further need to conduct research with people who use alcohol and drugs and have lived experiences with policing and mobile crisis response, as this qualitative research focused almost solely on people living with mental health challenges. It is crucial to consider the nature of trauma-informed, de-escalation and harm reduction approaches for people who use alcohol and drugs during crisis response in order to discern how service-oriented practices may reduce harms from alcohol and drug use and avoid punitive measures resulting from criminal legal and incarcerations involvement due to alcohol and drug use. Specifically there is a need to assess how systemic responses to people who use alcohol and drugs may result in fluctuating among multiple systems without well-integrated coordination of care.

ALTERNATIVE RESPONSES

CITY OF BERKELEY

NCJR
National Institute for
Criminal Justice Reform

Introduction and Report Overview

In the effort to provide meaningful information and recommendations to the Berkeley Reimagining Public Safety process, the National Institute for Criminal Justice Reform (NICJR) was tasked by the City Manager's Office to conduct research and analysis to produce a series of reports for the Taskforce, City of Berkeley (City) leadership and the public. NICJR reviewed the City Auditor's Calls for Services assessment, conducted further analysis of Berkeley Police Department Calls for Service (CFS), used the previously submitted New and Emerging Models of Public Safety report, and drew upon our team's experience and expertise, to develop this Alternatives Responses report.

This report provides an actionable roadmap for providing community and other non-law enforcement alternatives to a police response for 53 percent of CFS types for which the Berkeley Police Department (BPD) currently responds.

The initial section of this report presents the NICJR analysis of BPD's CFS and compares that analysis to the Berkeley City Auditor's report. The next section provides an overview of NICJR's alternative response model – Tiered Dispatch, which includes the Community Emergency Response Network (CERN) – and describes how specific call types are assigned to CERN tiers.

The report concludes with an overview of a framework for the City's alternative response model, drawing upon both existing and planned City resources. The specific parameters and scope of the Specialized Care Unit (SCU) have not yet been defined; but due to the public discourse and that the SCU development is housed in the City's Mental Health Division, the present analysis assumes that the SCU's role will be focused on mental-health related call responses.

Calls for Service Analysis

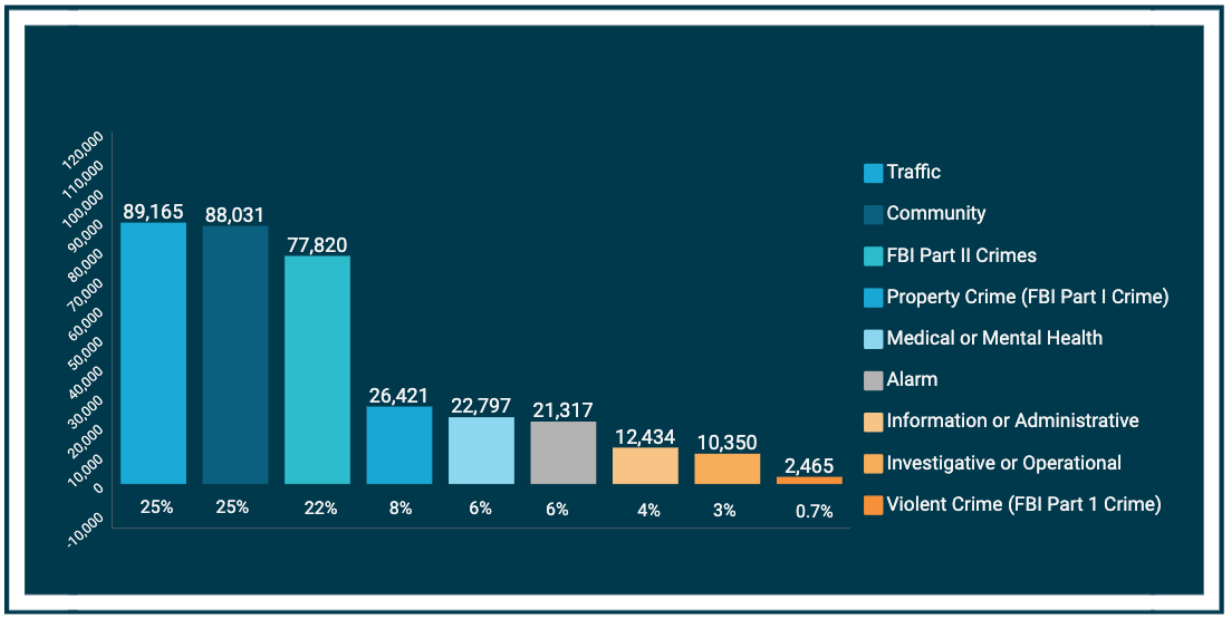
Summary of City Auditor Findings, NICJR Category Assignment and Crosswalk

The Berkeley City Auditor (Auditor) recently conducted an analysis of over 350,000 BPD calls for service covering calendar years 2015-2019. The BPD CFS audit, which can be found here, focused on the following questions:

1. What are the characteristics of calls for service to which Berkeley Police respond?
2. What are the characteristics of officer-initiated stops by Berkeley Police?
3. How much time do officers spend responding to calls for service?
4. How many calls for service are related to mental health and homelessness?
5. Can the City improve the transparency of Police Department calls through the City of Berkeley's Open Data Portal?

The Auditor categorized over 130+ call types into 9 categories in an effort to answer these questions: Violent Crime (FBI Part 1), Property Crime (FBI Part I), FBI Part II Crimes, Investigative or Operational, Medical or Mental Health, Information or Administrative, Community, Traffic, and Alarm.

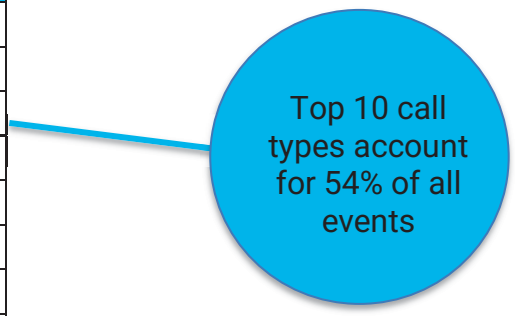
Figure 1. BPD Calls by Auditor Call Categories



Between 2015 and 2019 the Auditor found that BPD responded to an average of 70,160 CFS annually, and that ten call types accounted for 54 percent of all CFS.

Table 1. Top Ten Call Types, Auditor Report

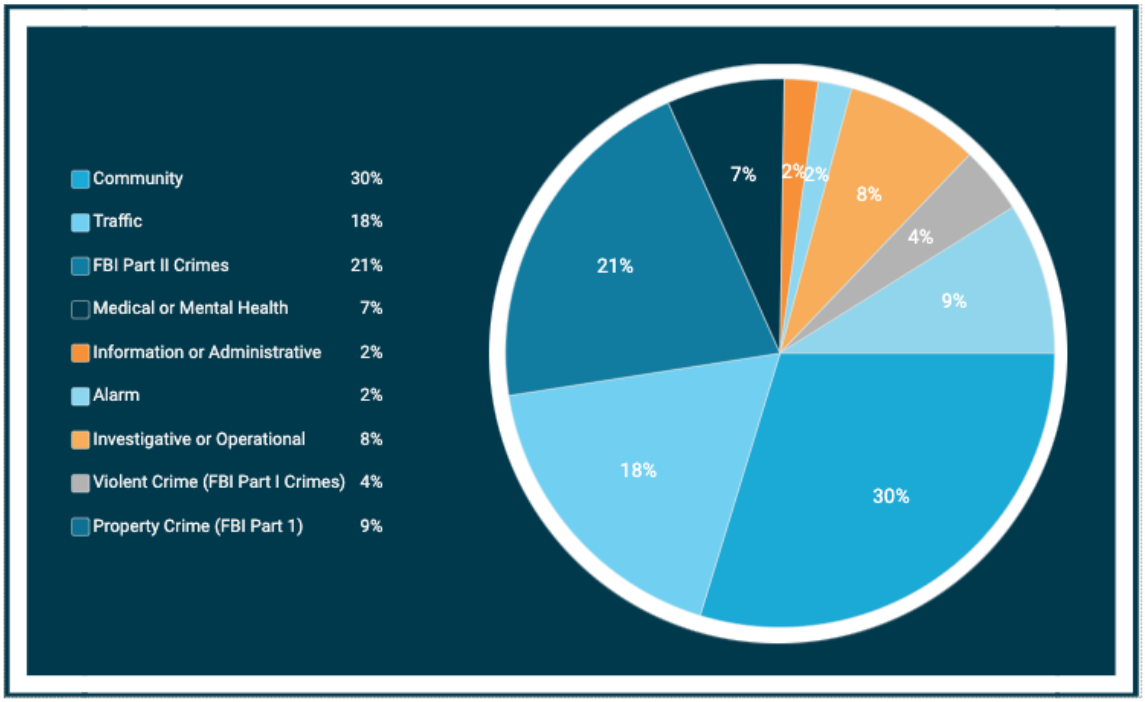
Call Types	Total Count
Traffic Stop	44,795
Disturbance	35,696
Audible Alarm	19,920
Noise Disturbance	15,773
Security Check	15,262
Welfare Check	15,030
Suspicious Circumstance	11,547
Trespassing	11,058
Theft	10,556
Wireless 911	9,899



The top ten call types fell into four categories: Traffic, Community, Alarm, and Property Crime. Mental health related CFS accounted for approximately 12 percent of all call types, while homelessness CFS accounted for 6.2 percent of all events. These types of CFS were identified by looking at keywords in narrative reports, disposition codes, call types, and/or Mobile Crisis Team response.

During the period reviewed, BPD officers spent most of their time (69 percent) responding to CFS that were categorized as Traffic (18 percent), Community (30 percent), or FBI Part II crimes (21 percent). Seven percent of BPD officers' time was spent handling Medical Mental Health CFS, another 9 percent on Property Crime CFS, and 2 percent on Alarms. The remainder of BPD officer time (14 percent) was spent on Information or Administrative, Investigative or Operational, and Violent Crime CFS.

Figure 2. BPD Officer Time Allocation, Auditor Report



NICJR Expands Upon Auditor's Analysis

As a first step in developing this Alternative Response Report, NICJR reviewed the CFS analysis completed by the Auditor and compared the results of that analysis to its own CFS classification results.

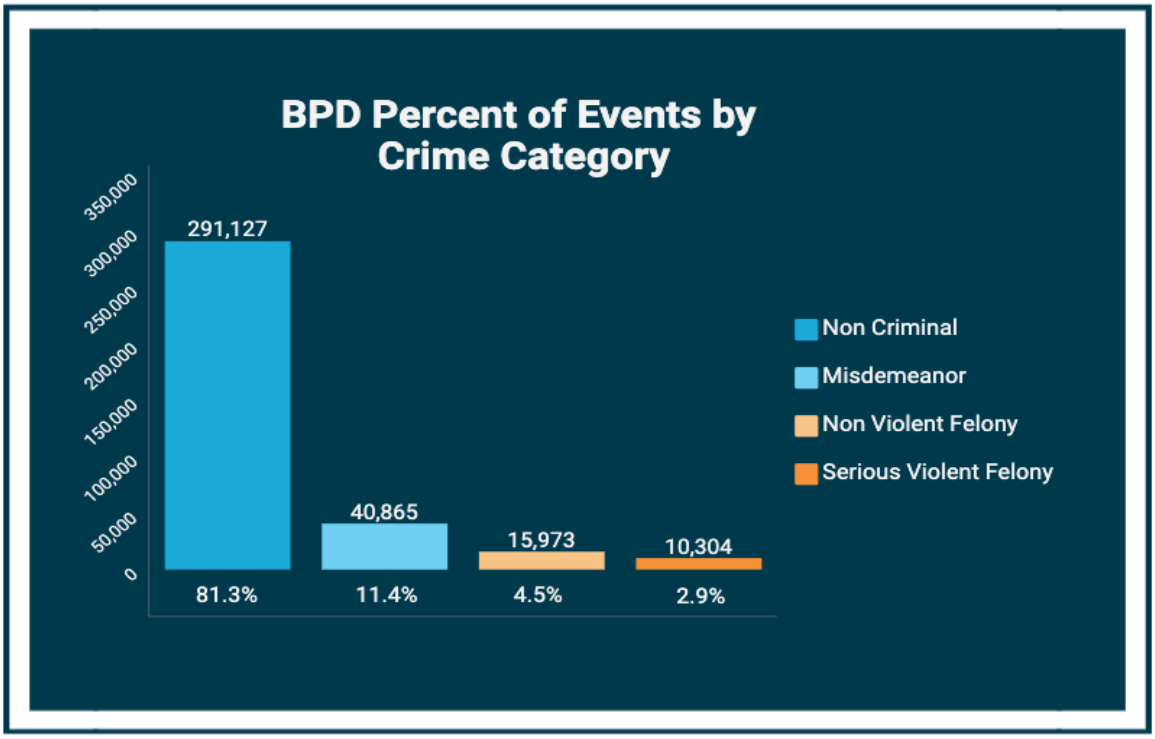
As outlined above, the Berkeley City Auditor aggregated all BPD call types into 9 categories, while NICJR uses 4 Categories to organize the same events. A crosswalk between the Auditor's 9, and NICJR's 4, CFS Categories is outlined in Table 2. NICJR categories are aligned with state specific penal codes and their associated penalties. If a call type is not found in the penal code, it is placed into the Non-Criminal Category.

Table 2. Crosswalk, Berkeley City Auditor and NICJR Call Type Categories

Berkeley Auditor Categories	NICJR Categories
Violent Crimes (FBI Part I)	Serious Violent Felony: Any event identified in the California Penal Code as a Serious Violent Felony
Property Crimes (FBI Part I)	Non-Violent Felony: Any event identified in the California Penal Code as a Non-Violent Felony
FBI Part II Crimes	Misdemeanor: Any event identified in the California Penal Code as a Misdemeanor Non-Violent and Serious Violent Felony
Community	Non-Criminal: Any event not identified in the Penal Code
Medical or Mental Health	
Traffic	
Informational or Administrative	
Investigative or Operational	
Alarm Calls	

NICJR uses this method of categorizing events because it affords the most linear association between the event and its associated criminal penalty. By categorizing events in this manner, NICJR can clearly identify the portion of CFS that are either non-criminal or are for low-level and non-violent offenses. Categorizing call data into a simple criminal vs. non-criminal, violent, vs. non-violent, structure also supports conversations with the community about alternatives to policing for specific call types grounded in easily understandable data.

Figure 3. BPD Events by NICJR Crime Category[1]



There were 22 call types[2] (11 percent) that differed in assignment when comparing the Auditor's report to NICJR results. A summary of these variances is outlined in Table 3 and described below.

Table 3. Key Variances, NICJR vs. Auditor Call Type Categorization

NICJR Classification	Auditor Classification	# of Impacted Call Types
Non-Criminal	FBI Part II Crimes	7
Serious Violent Felony	Traffic, Property Crimes (FBI Part I, FBI Part II Crimes	10
Non-Violent Felony	Investigative/Operational	1
Misdemeanor	Traffic, Informational or Administrative	4

[1] Figure excludes null or missing values in the dataset.
[2] There is a discrepancy in the number of call types evaluated by the Auditor versus NICJR. The Auditor evaluated approximately 130 CFS; NICJR, 183. Part of this discrepancy is due to the fact that the Auditor and NICJR reviewed slightly different data sets. Additionally, NICJR reviewed all CAD data while the Auditor only reviewed those CFS resulting in a sworn response.

Of the 22 call types, 7 (31.8 percent) were assigned to NICJR's Non-Criminal Category whereas the Auditor classified the same 7 as FBI Part II Crimes. For example, *family disturbance* is classified by the Auditor as a FBI Part II Crime while NICJR places it in the Non-Criminal Category. The largest source of variance between NICJR's Non-Criminal Category and the Auditor's classifications relates to the call type *disturbance*, which the Auditor classifies as an FBI Part II Crime while NICJR categorizes it as Non-Criminal. The *disturbance* call type accounted for nearly 10 percent of the 360,242 CFS reviewed in the Auditor's analysis.

Four out of the 22 (18.1 percent) differing call types were assigned to NICJR's Misdemeanor Category while the Auditor assigned them as Traffic and Informational or Administrative. These call types include *reckless driver, hit and run with injuries*, and *exhibition of speed.* Both *reckless driver* and *hit and run with injuries* were assigned as Traffic by the Auditor while NICJR assigns them as Misdemeanors. *Property Damage* was classified by the City Auditor as Informational or Administrative. NICJR classifies this call type as a Misdemeanor.

One out of the 22 (4.5 percent) differing call types, *lo jack stolen vehicle*, was assigned to NICJR's Non-Violent Felony Category while the Auditor assigned it as Investigative or Operational.

A final source of the variation in call type categorization between the Auditor and NICJR stems from NICJR's Serious Violent Felony assignment. The auditor used FBI UCR categories while NICJR used the California Penal Code to determine the penalty associated with the qualifying offense. Ten out of the 22 (45.4 percent) differing call types were assigned to NICJR's Serious Violent Felony Category. Out of the total 360,242 calls for service analyzed, NICJR classified 2.9 percent in the Serious Violent Felony Category. The Auditor only classified 0.7 percent of CFS in its Violent Felony Category. The variance is due to the fact that 9 call types classified by the Auditor as Traffic, Property Crime (FBI Part I), and FBI Part II Crimes fall into NICJR's Serious Violent Felony Category. This scenario is illustrated by the call types *hit and run with injuries* and *vehicle pursuit*. Both are classified by the Auditor as Traffic. NICJR classifies both calls in its Serious Violent Felony Category. Another example is *arson,* which is classified by the Auditor as Property Crime (Part I) while NICJR classifies *arson* as a Serious Violent Felony. Other call types generating this variance include battery, bomb threats, kidnapping, spousal or domestic abuse, child abuse, and sexual molestation.

The complete crosswalk is provided as Appendix A.

NICJR CERN Categorization

In our work to Reimagine Public Safety and transform policing, NICJR has developed a tiered dispatch system to provide alternatives to police response to CFS, increase public safety, and improve the quality of emergency response. This model includes the CERN, that builds upon NICJR's CFS classification structure.

Once each call type is associated with one of NICJR's four CFS Categories, they are given a default assignment on the Tiered Dispatch depicted in Figure4:

Figure 4. Tiered Dispatch

The Tiered Dispatch assignments for the 2015-2019 BPD CFS analyzed are outlined below.

Table 4. Tiered Dispatch Default Assignment Table

Crime Category	CERN	BPD	% of Call Types	# of Call Types in Each Tier
Tier 1	Only		50%	92
Tier 2	Lead	Present	14%	25
Tier 3	Present	Lead	9%	16
Tier 4		Only	27%	50

Default Tier Assignment Modified Based on Arrest Data and Other Factors

A. Arrest Rates

Subsequent to the default classification, NICJR examines arrest data to determine if adjustments to default Tier assignments are warranted. Most typically, this results in CFS "moving up" a Tier based on the likelihood of arrest. The arrest analysis includes the identification of the overall jurisdiction arrest rate, as well as the high-end of that rate, below which the vast majority of CFS arrest rates fall. For Berkeley, 10 percent was set as the arrest rate triggering Tier assignment review; only 6 of 91 CFS that resulted in an arrest had an arrest rate in excess of 10 percent in the years 2015 to 2019. Call types with arrest rates that significantly exceed the triggering arrest rate generally moved to higher Tiers. For example, the Non-Criminal CFS *warrant service* was moved from Tier 1 to Tier 4 based on arrest rate data.

Table 5. CFS CERN Tier Assignments After Arrest Review

Crime Category	CERN	BPD	% of Call Types	# of Call Types in Each Tier
Tier 1	Only		50%	91
Tier 2	Lead	Present	13%	24
Tier 3	Present	Lead	9%	16
Tier 4		Only	28%	52

B. Alternate Response Warranted

Beyond arrest data, CERN Tier assignment is modified based on NICJRs assessment of call types that would benefit from an alternate response. Some Serious Violent Felony call types typically move from Tier 4 to Tier 3 pursuant to this aspect of the analysis, in order to allow for a CERN response with an officer leading. For example, the call type *assault, gang related* has been downgraded from a Tier 4 to a Tier 3 in order to allow the CERN to assist officers involved. Warrants have similarly been downgraded from a Tier 4 to a Tier 3 with this rationale in mind. These call types would be lead by police only but members of the CERN would be present to provide family members with information and support. Conversely, some call types moved from lower to higher Tiers as a result of this aspect of the default Tier assignment modification methodology. Various events that fall under the assist call type, for example, are allocated to Tier 4 even though these CFS are Non-Criminal in nature. The rationale here is that if the BPD is being asked to assist another law enforcement agency, for example, a BPD response is required. Additionally, traffic related calls are in Tier 3 or 4 due to current state law requiring sworn officers, but in the event state law is amended as envisioned in some of the discussion related to BerkDOT, the calls would move to Tier 1. Appendix D includes calculations of calls and expenses with traffic calls shifted to Tier 1.

Table 6. CFS CERN Tier Assignments After Alternate Response Review

Crime Category	CERN	BPD	% of Call Types	# of Call Types in Each Tier
Tier 1	Only		53%	96
Tier 2	Lead	Present	11%	20
Tier 3	Present	Lead	20%	37
Tier 4		Only	16%	30

Based on NICJRs analysis, and as reflected in Table 6, 53 percent of BPD CFS could be handled by a community-response, only. A detailed breakdown of Berkeley CFS by CERN Tiers can be found in Appendix B.

Fiscal Implications of CERN Assignment

A major driver of the police reform conversation has been the desire to shift resources from traditional law enforcement to alternative, more appropriate, responses for specified types of calls for service. As Table 6 illustrates, the City can realistically expect to divert 53 percent of call types from the BPD to an alternate response that requires no law enforcement involvement. In order to understand the potential fiscal impact of the adoption of this type of alternate response model, various analyses of the BPD budget were conducted.

As outlined in Table 7, the BPD budget grew from approximately $61 million to $69 million during the period of CFS review, reflecting a nearly 15 percent increase; CFS remained steady during the same period, experiencing a slight decline of approximately 4 percent. The Police Operations Division budget, which houses costs associated with Patrol, comprised between 52 and 60 percent of the Department's budget during the review period; Patrol is responsible for responding to CFS in the City of Berkeley.

Table 7. BPD and Patrol Operations Division Budget, 2015-2019

	FY15	FY16	FY17	FY18	FY19
Total Budget	$60,832,054	$63,115,430	$66,428,530	$66,351,534	$69,567,103
General Fund (GF)	$57,057,838	$59,074,465	$62,156,096	$62,628,518	$65,493,664
Police Operations (OPS) Division	$34,781,350	$37,050,106	$39,867,224	$39,673,087	$36,284,878
OPS Division % of Total Budget	57.2%	58.7%	60.0%	59.8%	52.2%

In order to determine the proportion of Operations Division expenses that are directly attributable to responding to CFS, NICJR undertook several analyses:

Calculating Officer Time:

- Responding to CFS: On-Scene to Close. The time between when an officer arrives on-scene to a particular CFS and closes the call. This time frame is used to measure the actual time officers spend on calls for service. This calculation does not include travel time; the time officers take to write incident reports is only accounted for if the officer does this before a particular CFS is closed.
- Responding to CFS: Event Creation to Close. The time between when a call comes in and is created in the Computer Aided Dispatch (CAD) system and when an officer closes the call. This time period is used to capture the total amount of time from when a caller calls into the Communications Center to when an officer closes the call, accounting for the totality of time it takes to complete a CFS.
- Officer Time. Under either the On-Scene to Close or Event Creation to Close approaches, officer time is calculated based on the number of responding officers to a unique call multiplied by the amount of time spent on the call.

Identifying Median Officer Hourly Rates:

- Median hourly rates were generated from the City of Berkeley's Salary List for benefited employees. The minimum salary (step 1) in that schedule is $49.73/hr and the maximum, (step 7), $61.90/hr. The median salary is $56.24 (step 4).

Applying Applicable Overhead Rate to Median Officer Hourly Rate:

- As of the City's 2021 Benefits and Compensation Matrix, this rate was 110 percent.

The results of this analysis are provided in Table 8.

Table 8. Cost of Responding to CFS: On-Scene to Close and Create to Close

Officer Costs Associated with Responding to CFS: On-Scene to Close	
Total Hours 2015 - 2019, CERN Tier 1 Calls (BPD Response Hours)	98,119
Total Hours 2015-2019, All other CERN Tiers (BPD Response Hours)	89,525
Median BPD Officer Salary	$56.24
BPD Officer Salary Range	$49.73 - $61.90
Berkeley Composite Fringe Benefit Rate	110%
Calculation of CERN Tier 1 Costs (# of hours * Median Salary * Benefit Rate)	$13,166,026
Calculation of All other CERN Tier Costs (# of hours * Median Salary * Benefit Rate)	$8,995,481
Average Annual CERN Tier 1 Officer Costs, On-Scene to Close	**$2,633,205**
Average Annual Officer Costs Tiers 2-4	**$1,799,096**

Officer Costs Associated with Responding to CFS: Create to Close	
Total Hours 2015 - 2019, CERN Tier 1 Calls (BPD Response Hours)	266,832
Total Hours 2015-2019, All other CERN Tiers (BPD Response Hours)	367,422
Median BPD Officer Salary	$56.24
BPD Officer Salary Range	$49.73 - $61.90
Berkeley Composite Fringe Benefit Rate	110%
Calculation of CERN Tier 1 Costs (# of hours * Median Salary * Benefit Rate)	$34,106,771
Calculation of All other CERN Tier Costs (# of hours * Median Salary * Benefit Rate)	$40,801,102
Average Annual CERN Tier 1 Officer Costs, Create to Close	**$6,821,354**
Average Annual Officer Costs Tiers 2-4	**$8,160,220**

Depending on the officer time calculation used, and using 2019 budget data alone, the costs associated with responding to Tier 1 CFS range from between **approximately 7 (On-Scene to Close) and 19 (Create to Close)** percent of the Police Operations Division budget, and **4 and 10** percent of the total BPD budget. Costs associated with responding to CFS Tiers 2-4 comprise between approximately **5 (On-Scene to Close) and 23 (Create to Close)** percent of the Police Operations Division budget and **3 and 12** percent of the total BPD budget.

Table 9. Tier 1 CFS as % of Operations Division and BPD Overall Budget

	Tier 1 Costs: On-Scene to Close	Tier 1 Costs: Create to Close	Tier 2-4 Costs: On-Scene to Close	Tier 2-4 Costs: Create to Close
% of OPS Budget	7.3%	18.8%	4.9%	22.5%
% of BPD Budget	3.8%	9.8%	2.6%	11.7%

This analysis suggests that under any scenario, officer time associated with responding to *all* calls for service accounts for less than half of the Police Operations Division budget. When looking at officer time associated with directly responding to calls for service, NICJR used the time from when an officer arrives on-scene until the time an officer clears the call to go back in service. NICJR also assessed the total amount of time it takes for BPD to resolve a call, which looks at the time between when a call comes into the communications center and when the officer clears a call to go back in service. As noted in tables 8 and 9, On-Scene to Close (Tier 1), comprises just 39 percent of Create to Close (Tier 1) costs ($2,633,205 vs. $6,821,220). This result suggests that the majority of costs are NOT associated with on-scene response.

Another approach to estimating anticipated cost savings associated with CERN Tier 1 implementation converts the estimated number of officer hours saved into FTEs as reflected in Table 10 on the following page.

Table 10. CFS FTE Analysis

CERN Tier	Total Hours (Create to Close) (Avg Annual)	Average Hours[3], 1 FTE Officer	Estimated # of FTE Per Tier
1	53,366	2080	25.7
2	24,012	2080	11.5
3	32,331	2080	15.5
4	17,140	2080	8.2

[3] 2080 is the standard number of working hours per year for a full-time equivalent position; BPD actual annual hours/FTE may vary.

Redirection of Tier 1 CFS to a CERN would thus generate approximately $6.8 million in annual BPD savings annually, equating to slightly less than 26 FTE.

Building the Alternative Response Infrastructure

In order to facilitate the development of Berkeley's own alternate response network or CERN, NICJR further analyzed the 92 CFS in CERN Tier 1. Although an alternate response is also contemplated in response to CFS in Tiers 2 and 3, as the CFS category which contemplates no corresponding police response, Tier 1, is an appropriate focal point for initial alternate response analyses.

To facilitate this assessment, Tier 1 CFS were divided into 11 topical/activity- based sub-categories as outlined in Table 11.

Table 11. CERN Sub-Category

CERN Category	Definition	Example Call Type(s)
Administrative	Calls that involve administrative duties	subpoena service; VIN verification; information bulletins, test call, report writing
Alarm	Calls that involve activation of alarms	residential alarm, commercial alarm, bank alarm, audible alarm, GPS alarm
Animal	Calls that involve animals	stray animals, barking dogs, cat in a tree
Investigation	Calls that require some form of investigation to ensure all is in order	investigating an open door, residential welfare checks, business premise checks, follow up on previous crime to collect evidence (witness statements, video footage, etc.)
Medical or Mental Health	Calls that require or involve medical or mental health assistance	mutual aid medical support, gunshot victim, suicide, 5150 transport
Municipal	Calls that involve municipal issues	fall on city property; COVID-related violations; BPC violations - signage, lighting, etc.; sidewalk regulations
Other	Call types that do not fit into any of the other CERN categories	create new call; no longer used, wireless 911 call got dropped
Public Order	Calls that interfere with the normal flow of society	demonstrations, civil unrest
Quality of Life	Calls that create physical disorder or reflect social decay	loitering (homeless), panhandling, noise, trash/dumping, urinating in public
Substance Use	Calls that involve substance use	open air drug use and distribution, overdose related, down and out, public intoxication
Traffic	Calls that involve traffic or vehicle related concerns	abandoned vehicles

Leveraging Existing and Planned City Resources and Ideas from New and Emerging Models Report

CERN Team Types
The Community Emergency Response Network may need to have different types of teams that respond to certain calls.

- SCU: Respond to Mental Health & Drug issue calls
- Mediation Team: Respond to Disturbance and Noise calls
    - Possibly include specialists in Family Disturbance calls
- Report Takers/Technicians: Take crime reports
    - Specialists for evidence collection as the city has now
- Outreach: Respond to non-MH homeless calls, welfare checks, etc
- BerkDOT: Respond to traffic calls
    - Including technology

In an effort to identify existing and planned resources by Tier 1 Category, NICJR reviewed:

- The list of City-funded community-based organizations (CBOs) provided in the City Manager's Proposed Annual Budget Fiscal Year 2022, submitted to the City Council on May 25, 2021;
- City Boards, Commissions, and Departments, as identified on the City's website; and
- Relevant examples of potential programs or approaches as provided in the New and Emerging Models of Community Safety and Policing Report
- Other relevant local CBO's/resources

Table 12, which can be found on the next several pages, summarizes the results of NICJRs services scan; a list of the specific CBOs identified by Tier 1 sub-category can be found in Appendix C. A detailed description of each Table 12 organizing category follows.

Table 12. CERN Build Out: CBO's, City Departments, Other Resources

CERN Category	Call Type(s)	Existing City-Contracted CBOs	Existing City Departments	Planned City Resources	Other Relevant Resources	Potential Oversight Commission/Board	Innovations, New and Emerging
Administrative	subpoena service; VIN verification; information bulletins, test call, report writing			BerkDOT (VIN verification)	Private subpoena servers		
Alarm	residential alarm, commercial alarm, bank alarm, audible alarm, GPS alarm	The Downtown Berkeley Association/ Downtown Ambassadors Street Team provides alarm assistance services			UCPD Community Service Officers provides alarm assistance services		
Animal	stray animals, barking dogs, cat in a tree etc.	Animal Rescue	City Manager's Office: Berkeley Animal Care Services			Animal Care Commission	

CERN Category	Call Type(s)	Existing City-Contracted CBOs	Existing City Departments	Planned City Resources	Other Relevant Resources	Potential Oversight Commission/Board	Innovations, New and Emerging
Investigation	investigating an open door, residential welfare checks, business premise checks, follow up on previous crime to collect evidence (witness statements, video footage, etc.)	Downtown Berkeley Association/ Downtown Ambassadors Street Team: investigating open doors, residential welfare checks, business premise checks			UCPD Community Service Officer (CSO) Program: investigating open doors, residential welfare checks, business premise checks		

CERN Category	Call Type(s)	Existing City-Contracted CBOs	Existing City Departments	Planned City Resources	Other Relevant Resources	Potential Oversight Commission/Board	Innovations, New and Emerging
Medical or Mental Health	mutual aid medical support, gunshot victim, 5150 transport, mental illness, suicide attempt, threat of suicide, mental health	4 CBOs contracted for health services; 1 CBO contracted for mental health services (Alameda County Network of Mental Health Clinics); several homeless oriented CBOs include a mental health component	Fire Department; Mental Health Division Mobile Crisis Team, and Crisis, Assessment, and Triage Team (loitering, panhandling, urinating in public); Health, Housing, and Community Services Department	SCU	Bonita House's Bridges to Recovery In-Home Outreach Team (IHOT) Bonita House's Community Assessment & Transportation Team (CATT) program New Bridge Foundation: drug and alcohol rehabilitation center in Berkeley, California that offers inpatient and outpatient services as well as detoxification treatment	Community Health Commission; Mental Health Commission	Crisis Response Unit (CRU), Olympia, Washington
Municipal	fall on city property; COVID-related violations; BPC violations - signage, lighting, etc.; sidewalk regulations		City Manager's Office: Code Enforcement, Public Works			Public Works Commission	

CERN Category	Call Type(s)	Existing City-Contracted CBOs	Existing City Departments	Planned City Resources	Other Relevant Resources	Potential Oversight Commission/Board	Innovations, New and Emerging
Other	create new call; no longer used, wireless 911 call got dropped	NA	NA	NA	NA	NA	NA
Public Order	Demonstrations, civil unrest	Downtown Berkeley Association's Safety Ambassadors Program: provides public order services/ assistance			UCPD Community Service Officer (CSO) Program: provides public order services/ assistance		

CERN Category	Call Type(s)	Existing City-Contracted CBOs	Existing City Departments	Planned City Resources	Other Relevant Resources	Potential Oversight Commission/Board	Innovations, New and Emerging
Quality of Life	loitering (homeless), panhandling, noise, trash/dumping, urinating in public	16 CBOs contracted for homeless services, approximately 50% with case management component. These resources could be leveraged to address loitering, panhandling, and public urination/intoxication complaints. Other CBOs (Eden Information and Referral as well Telegraph Business Improvement District) assist with quality of life calls as well. Downtown Berkeley Association's Safety Ambassadors Program: all Quality of Life CFS	Mental Health Division, Mobile Crisis, and Crisis, Assessment, and Triage Team (loitering, panhandling, urinating in public); City Manager's Office: Code Enforcement (trash/dumping)		UCPD Community Service Officer (CSO) Program: all Quality of Life CFS	Homeless Commission; Human Welfare and Community Action Commission	Mayor's Action Plan (MAP) for New York City

CERN Category	Call Type(s)	Existing City-Contracted CBOs	Existing City Departments	Planned City Resources	Other Relevant Resources	Potential Oversight Commission/Board	Innovations, New and Emerging
Substance Use	open air drug use and distribution, overdose related, down and out, public intoxication	1 CBO directly contracted for substance abuse services (Options Recovery Services); other homeless-oriented CBO's provide various substance abuse related services	Mental Health Division Mobile Crisis Team, and Crisis, Assessment, and Triage Team (loitering, panhandling, urinating in public)		New Bridge Foundation: drug and alcohol rehabilitation center in Berkeley, California that offers inpatient and outpatient services as well as detoxification treatment Bonita House's Bridges to Recovery In-Home Outreach Team (IHOT) Bonita House's Community Assessment & Transportation Team (CATT) program	Health Commission, Community; Homeless Commission; Mental Health Commission	Arlington Opiate Outreach Initiative
Traffic	abandoned vehicles, speeding, reckless driving		City Manager's Office: Code Enforcement (abandoned vehicles)	BerkDOT		Transportation Commission	NYPD Staten Island's Motor Vehicle Accident Program

CERN Category	Call Type(s)	Existing City-Contracted CBOs	Existing City Departments	Planned City Resources	Other Relevant Resources	Potential Oversight Commission/Board	Innovations, New and Emerging
Weapon	person with a gun				Building Opportunities for Self-Sufficiency appears to be only City-contracted CBO with significant experience with and focus on incarcerated/formerly incarcerated. May be a resource for this particular CFS and others in that vein.	Peace and Justice Commission	

Existing City-Contracted Community Based Organizations

NICJR reviewed all City-contracted CBO's and, where possible, aligned CERN Tier 1 sub-categories with community-based organizations; identified organizations are those that could potentially be leveraged to build out the CERN approach. Although the City contracts with a number of CBO's, there is a significant concentration in homeless services, with few contracted providers in many of the other CERN Tier 1 sub-categories. Where able to identify, NICJR has lifted up those CBO's working in any area that appear to be doing some type of case management or street outreach work, as well as those that have experience with a criminal justice population. These organizations are likely best positioned to serve as the starting point for the development of the CERN infrastructure. There is at least one City-contracted CBO that NICJR is aware of that engages in case management and outreach work *and* has extensive experience with justice-involved community members; that organization, Building Opportunities for Self Sufficiency (BOSS), is an obvious candidate to serve as one of the City's anchor and foundational CERN partners. BOSS is an example of a capable organization, there are others in Berkeley and the city would need to conduct a Request for Proposals process to select the most appropriate service providers.

The Downtown Berkeley Association (DBA), an independent non-profit organization that has recently contracted with the City, provides a variety of services including but not limited to cleaning and beautification, hospital and outreach, marketing and business support, and prevention of crime and other threats to merchants.[4] Positions encompass hospitality workers, cleaners, social workers, and trained guards, known as Safety Ambassadors. Safety Ambassadors carry batons, pepper spray, and handcuffs and are outfitted with neon vests.

Safety Ambassadors often have backgrounds in law enforcement and are required to undergo an 8-hour general training along with additional trainings covering topics such as sexual harassment, mental illness, and de-escalation tactics. The stated objective of this program is to increase the quality of life in downtown Berkeley and ensure that any potential disturbances are curtailed.[5] Low-level municipal or quality of life violations, open use of illicit drugs, and threats to businesses are all addressed by the Safety Ambassadors. As such, the DBA itself may serve as an important CERN resource. However, it is important to note that many community members and organizations have expressed concerns with the enforcement-type equipment that Safety Ambassadors carry.

Lastly, the Mental Health Division's (MHD) Mobile Crisis Team provides immediate crisis intervention services for the community and supports BPD in capacities including co-responding to calls for service upon BPD request. This Team, as well as the MHD's Crisis, Assessment, and Triage Team, are obvious foundations for the SCU which is currently under development. The Mobile Crisis Team has very limited resources and

[4] https://www.downtownberkeley.com

[5] https://www.berkeleyside.org/wp-content/uploads/2020/09/Safety-Ambassador-Pilot-Program-2-Month-Report.pdf

available hours. At the time of this report, the Team only has two members. In Listening Sessions held with BPD officers, many expressed the need to expand the good work of the Mobile Crisis Team.

Existing City Departments

There are a number of City Departments that are either currently, or could, be deployed to address CERN Tier 1 sub-categories. For example, the BPD currently partners with the Mental Health Division's Mobile Crisis Team, and the Code Enforcement Unit within the City Manager's Office is responsible for addressing illegal dumping. The roles and responsibilities of existing City Departments could be expanded to support absorption of specific Tier 1 CFS. BPD also employs civilian technicians who could be used to take reports or collect evidence in cold CFS that may not need an officer present.

Existing Berkeley Commissions, Boards and Departments

NICJR reviewed the City's Boards and Commissions to identify those that might be most appropriate for supporting the development and oversight of various components of the CERN. While ultimately the effort is likely most effectively administered by a single oversight body, the development of various components of the alternate response model may lend itself to disaggregation by topic, although an effective coordination and overall project management approach should be employed from the outset.

Planned City Resources

The City has two significant alternative response initiatives currently underway: the Berkeley Department of Transportation (BerkDOT) and the Specialized Care Unit (SCU). While the scope of these efforts is unclear, NICJR has assigned Tier 1 sub-categories to these City-initiated alternate responses as follows:

- BerkDOT: All traffic CFS
- SCU: All mental health and drug use CFS

The following relevant excerpts from the City Manager's *Proposed Annual Budget Fiscal Year 2022* suggest that the 2021-2022 budget year is a planning period for BerkDOT, while the SCU is on more accelerated implementation timeline:

BerkDOT

"The Public Works Department is evaluating the potential to create a Berkeley Department of Transportation to ensure a racial justice lens in traffic and parking enforcement and the development of transportation policy, programs, and infrastructure.[6]

- Estimated Budget: $75,000
- Description: Develop plans for establishing a Berkeley Department of Transportation to ensure racial justice and equity in Transportation policies,

[6] Page 24, *Proposed Annual Budget Fiscal Year 2022*

programs, services, capital projects, maintenance, and enforcement. Coordinate this with the Reimagining Public Safety effort."

Current state law does not allow non-law enforcement to conduct traffic stops. Given the City's decision to establish BerkDOT, in Appendix D we have assigned all traffic CFS to CERN Tier 1.

SCU

"The Health, Housing and Community Services Department is working with a steering committee to develop a pilot program to re-assign non-criminal police service calls to a Specialized Care Unit."[7]

- $8 million is currently allocated for programs addressing community safety and crisis response.[8]
- Before the SCU is deployed, community safety concerns have been proposed to be addressed through:
    - Expanding prevention and outreach
        - Leverage existing teams and CBOs
        - Address basic needs (i.e., wellness checks, food, shelter)
        - Equipment and supplies
        - Estimated budget: $1.2 million
    - Crime prevention and data analysis to support data driven policing and identify areas of community need
        - Establish data analysis team (2 non-sworn positions)
        - Deploy Problem Oriented Policing Team (overtime)
        - Estimated budget: $1.0 million

Other Relevant Resources

NICJR has identified three non-City funded CBOs as potential alternate response providers related to Tier 1 sub-categories: the New Bridge Foundation (NBF); Bonita House's Community Assessment and Transport Team (CATT) and Bridges to Recovery In-Home Outreach Team (IHOT); and the University of California's Community Service Officer Program. Again, these are examples, the city would need to conduct a Request for Proposals process to select the most appropriate service providers.

New Bridge Foundation

NBF was identified as a possible alternative solution by Berkeley Reimagining Public Safety Task Force Members. NBF is a residential and outpatient addiction treatment center that provides comprehensive services and has a community outreach component to their program. NBF was assigned to the Tier 1 sub-category, substance use.

Bonita House

[7] Page 24, *Proposed Annual Budget Fiscal Year 2022*

[8] https://www.cityofberkeley.info/uploadedFiles/Clerk/Level_3_-_City_Council/FY%202022%20CM%20Proposed%20Budget%20Recommendations.pdf

While Bonita House receives City funding for its Creative Wellness Center (CWC) which serves as an entry point for recovery and supportive services for people with mental health needs and co-occurring conditions, it does not currently receive financial support for its *Community Assessment and Transport Team (CATT)*; a crisis response system to get clients "to the right service at the right time", or its *Bridges to Recovery In-Home Outreach Team (IHOT)*; a short-term outreach, engagement and linkage to community services program for individuals with severe mental illness. Both of these teams could potentially play important roles in a new alternate response network.

University of California Police Departments (UCPD)
Most University of California Police Departments (UCPD) have some type of Community Service Officer (CSO) Program. CSOs are uniformed, civilian personnel comprised of students that assist the UCPD in a variety of ways. They provide evening and night escorts, patrol campus buildings and residence halls, perform traffic control duties, and act as liaisons between university students and their corresponding police departments.[9] CSOs generally carry pepper spray and work anywhere from 10-20 hours each week. The majority of UCPD CSO Programs also employ tasers.[10] Some are trained to aid in cases of medical emergencies.[11] General security and deterrence of crime are the goals of the CSO program.[12]

At UC Berkeley, the CSO Program is made up of 60 part-time students. CSOs offer the BearWalk, a night escort for all faculty and students at the University. Berkeley CSOs are also contracted to patrol residence areas and university buildings. Often, CSOs assist in special events or sports games to promote safety and security. Applicants to the CSO Program must be in good academic standing, undergo a background check, and an oral board interview as part of the hiring process.[13] Because the CSO program is already established in the campus area, it may make sense for the City to partner with the University to expand the responsibilities of this student-staffed community service to include for example responding to suspicious circumstances or vehicles CFS. Other example CSO activities include processing complaints and taking reports.

New and Emerging Models
In addition to reviewing existing and planned local resources, NICJR reviewed the New and Emerging Models of Community Safety and Policing Report, to identify programs that might be appropriate for Berkeley implementation. Five initiatives were identified pursuant to this review: San Francisco's Street Crisis Response Team (SCRT); Olympia, Washington's Crisis Response Unit (CRU); Mayor's Action Plan (MAP) for New York City; The Arlington Opiate Outreach Initiative; and NYPD Staten Island's Motor Vehicle Accident Pilot Program.

[9] https://www.police.ucla.edu/cso
[10] https://dailybruin.com/2006/11/28/a-closer-look-uc-campuses-exhi
[11] https://police.ucsd.edu/services/cso.html
[12] https://www.police.ucla.edu/cso/about-cso
[13] https://ucpd.berkeley.edu/services/community-service-officer-cso-program

The Street Crisis Response Team (SCRT) is a pilot program administered by the Fire Department in San Francisco, California, for individuals experiencing a behavioral health crisis. SCRT Teams consist of a behavioral health specialist, peer interventionist, and a first responder who work in 12-hour shifts. 911 calls that are determined to be appropriate for the SCRT are routed to SCRT by dispatch. A team responds in an average of fifteen minutes.

The City of Olympia, Washington implemented their **Crisis Response Unit (CRU)** in April of 2019 to serve as an option for behavioral health calls for service. The CRU teams consist of mental health professionals that provide supports such as mediation, housing assistance, and referrals to additional services to their clients. Calls for service for the CRU originate from community-based service providers, the City's 911 hub, and law enforcement personnel.

The Mayor's Action Plan (MAP) for New York City (NYC**)** was launched in 2015 in fifteen NYC Housing Authority properties with high violence rates in order to foster productive dialogue between local residents and law enforcement, address physical disorganization, and bolster pro-social community bonds. MAP's focal point is NeighborhoodStat, a process that allows residents to have a say in the way NYC allocates its public safety resources. Early evaluations show a reduction in various crimes as well as increased perception of healthier neighborhoods.

The Arlington Opiate Outreach Initiative was established in 2015 in Arlington, Massachusetts, and brings together social workers, community-based organizations, and public health clinicians housed in the Arlington Police Department in order to foster relationships with residents of the community and then connect them to treatment and supports. Individuals in the community are identified for possible treatment after frequent police encounters, prior history of drug usage, or previous hospitalization related to overdoses.

NYPD Staten Island's **Motor Vehicle Accident Pilot Program** is aimed at reducing the number of calls for service related to minor collisions. When a call for service comes in regarding a collision, dispatch will determine if the collision is minor or serious enough to merit police response. If the collision is deemed to be minor, all individuals involved in the crash will simply complete a collision report and then exchange contact information.

Community Survey

In partnership with the City of Berkeley's (City) Reimagining Public Safety Task Force and the City Manager's Office, Bright Research Group (BRG) conducted an online-based community survey (survey) in both English and Spanish between May 18 and June 15, 2021. The survey was disseminated by the City of Berkeley, the Reimagining Public Safety Task Force, community-based organizations, and other key partners. The survey

was designed to gather insight into residents' perceptions and experiences in three primary areas: the Berkeley Police Department (BPD) and crisis response; priorities for reimagining public safety; and recommendations for alternative responses for calls for service.

Survey Summary

Community Safety

While most survey respondents indicated that they view Berkeley as safe or very safe, these results were not consistent across all demographic groups. Slightly over 30 percent of respondents perceived Berkeley as safe or very safe; an additional 46.4 percent of respondents perceived Berkeley as somewhat safe. White residents were more likely to perceive Berkeley as safe or very safe; Black, Latin, Asian and Other Non-white residents were more likely to perceive Berkeley as unsafe or very unsafe.

Figure 5. How safe do you think Berkeley is?

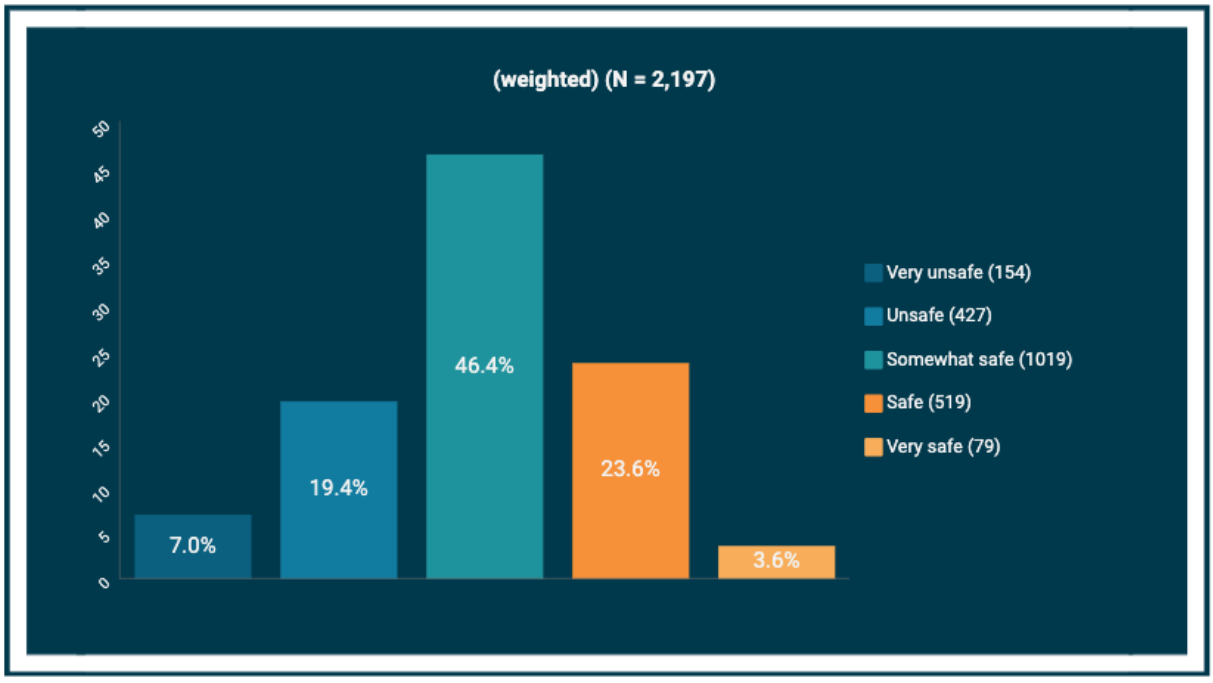


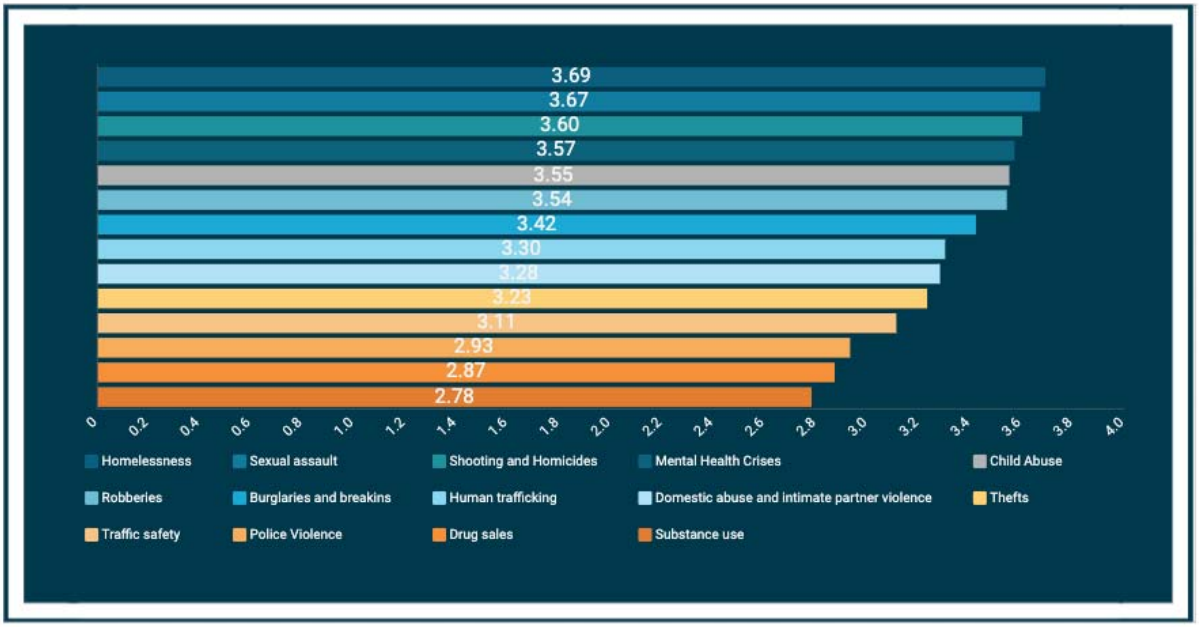
Table 13. How safe do you think Berkeley is? By race and ethnicity.

	White N = 1,622	**Black** N = 139	**Latin** N = 103	**Asian** N = 159	**Other Nonwhite** N = 168	**Undisclosed** N = 478
Very unsafe	4.0%	14.4%	9.7%	7.5%	15.5%	19.5%
Unsafe	14.7%	25.9%	25.2%	24.5%	23.2%	34.9%
Somewhat safe	50.5%	36.0%	46.4%	45.3%	46.4%	33.1%
Safe	26.2%	22.3%	13.1%	20.8%	13.1%	10.0%
Very safe	4.6%	1.4%	1.8%	1.9%	1.8%	2.5%

Key Public Safety Concerns

Survey respondents ranked homelessness and sexual assault as the most important public safety concerns. These were followed by shootings and homicides and mental health crises. The lowest priorities were substance use, drug sales, and police violence.

Figure 6. How important are the following issues to community health and safety in Berkeley to you? (weighted)[14]



Nearly half of survey respondents reported experiencing street harassment, and 41 percent reported being the victim of a crime. Black survey respondents reported experiencing higher rates of mental health crisis, homelessness, and family victimization, as well as police harassment and arrest, than did other survey respondents.

Patterns in priorities for safety were consistent across race and ethnicity, except for survey respondents with an undisclosed race and ethnicity.

When assessing the findings on priorities of Berkeley residents for community health and safety, survey respondents ranked investments in mental health, homeless and violence prevention services highest. There are differences along race and ethnicity for investment priorities, with White respondents rating all listed programs higher overall. Black respondents were also rated an investment in mental health services higher in comparison to other prevention services.

[14] 4: very important; 3: important; 2: somewhat important; 1: not important

Figure 7. How important is it to you for the City of Berkeley to invest in each of these programs and services to ensure a public safety system that works for all? (weighted)[15]

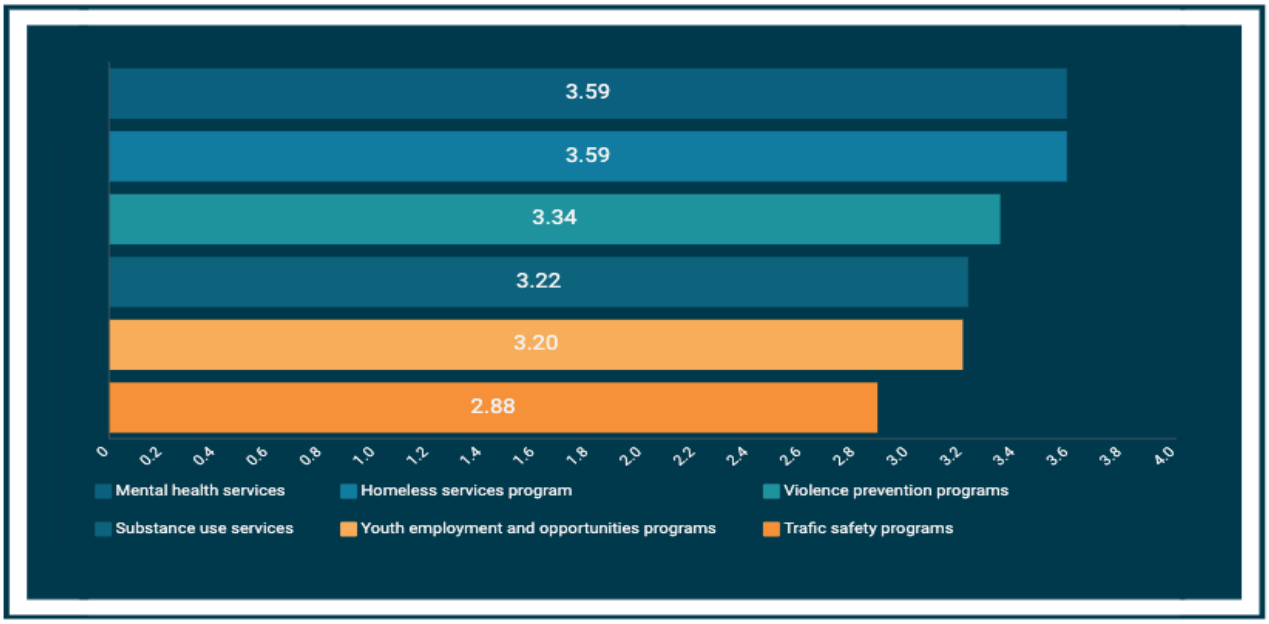


Table 13. How important is it to you for the City of Berkeley to invest in each of these programs and services to ensure a public safety system that works for all? By race and ethnicity.[16]

	White N = 1,599	**Black** N = 136	**Latin** N = 103	**Asian** N = 154	**Other Nonwhite** N = 167	**Undisclosed** N = 462
Not effective at all	6.8%	8.8%	4.9%	5.2%	10.2%	5.2%
Somewhat effective	36.3%	36.0%	41.7%	43.5%	30.5%	35.9%
Effective	43.4%	27.2%	32.0%	35.1%	39.5%	34.0%
Very effective	13.4%	27.9%	21.4%	16.2%	19.8%	24.9%

[15] 4: very important; 3: important; 2: somewhat important; 1: not important
[16] very important; 3: important; 2: somewhat important; 1: not important

Views on the Berkeley Police Department

A majority of respondents (53.3 percent) perceived the BPD as being effective or very effective. Only 6.7 percent of respondents perceived BPD as being not effective at all. Nonwhite respondents were more likely to indicate that BPD is not effective at all, while White respondents were more likely to indicate that BPD is effective.

When assessing experiences of residents when contact is made with BPD, survey results found that almost 75 percent of respondents who indicated they've had contact with BPD indicated their experience was positive or very positive, while Black and Asian residents were more likely to report negative experiences with BPD.

Table 14. When it comes to public safety, how effective is the Berkeley Police Department? By race and ethnicity.

	White N = 1,599	**Black** N = 136	**Latin** N = 103	**Asian** N = 154	**Other Nonwhite** N = 167	**Undisclosed** N = 462
Not effective at all	6.8%	8.8%	4.9%	5.2%	10.2%	5.2%
Somewhat effective	36.3%	36.0%	41.7%	43.5%	30.5%	35.9%
Effective	43.4%	27.2%	32.0%	35.1%	39.5%	34.0%
Very effective	13.4%	27.9%	21.4%	16.2%	19.8%	24.9%

Views on Alternative Responses to Calls for Service

A large majority of survey respondents (81 percent) among all racial and ethnic groups indicated a preference for trained mental health providers to respond to calls related to mental health and substance use, with most also indicating that police should be available to support a response to those calls if needed.

An even greater percentage (83.6 percent) of survey respondents indicated a preference for homeless services providers to respond to calls related to homelessness, with police present when necessary.

Figure 7: Who should respond to calls related to mental health and substance use?

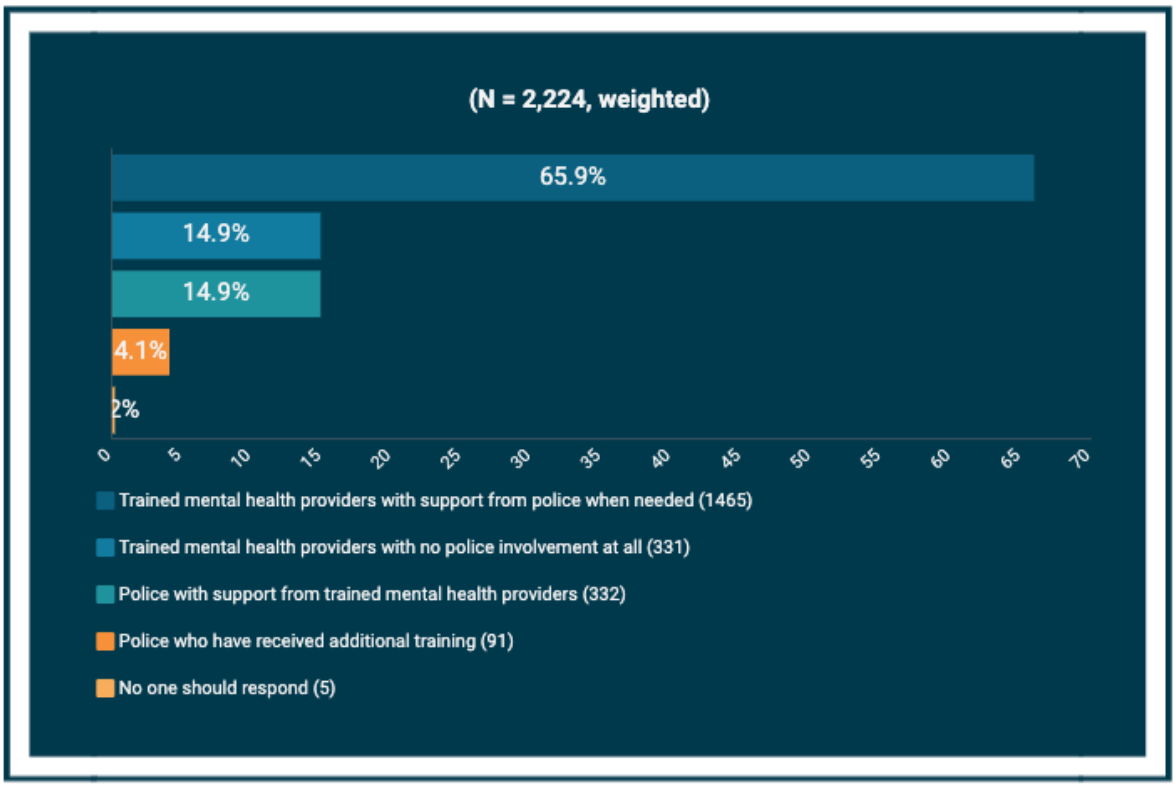
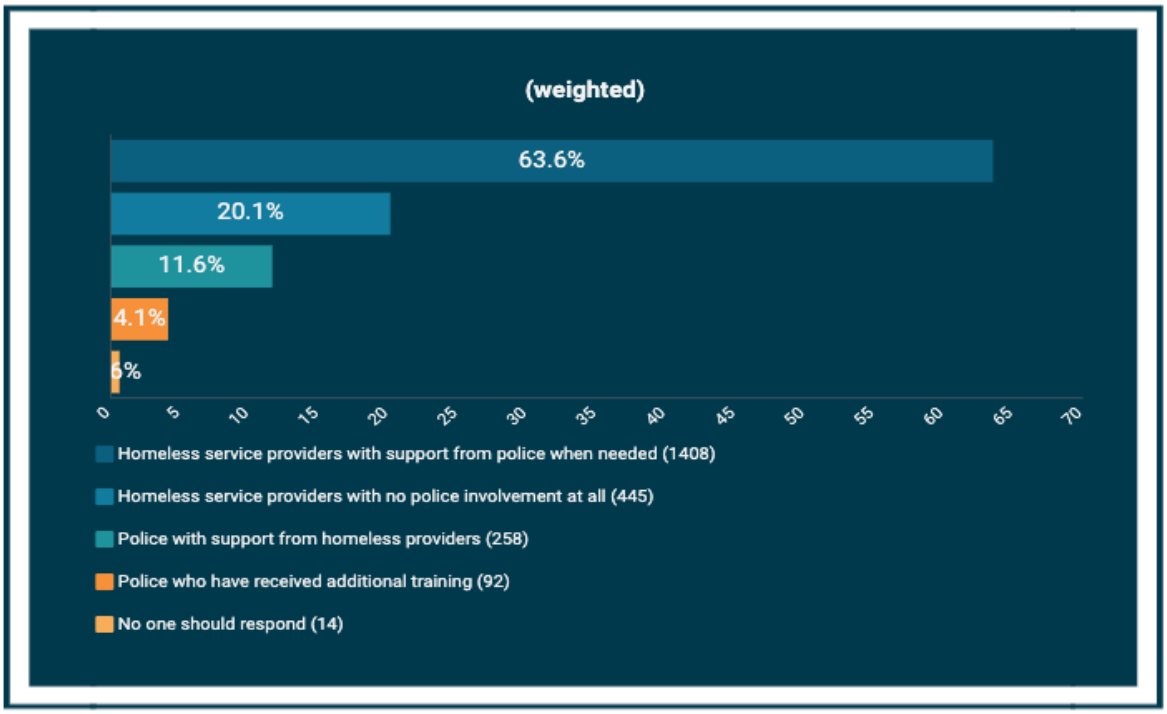


Figure 8. Who should respond to calls related to homelessness?



Focus Group Feedback

In collaboration with NICJR, Bright Research Group facilitated a series of focus groups to gather data on community sentiment regarding the current state of public safety, the role of the Berkeley Police Department (BPD), and the future of public safety. Outreach to Black, Latino, system-impacted, and unstable housed/ food-insecure residents was facilitated by the McGee Avenue Baptist Church, Center for Food, Faith, and Justice, and the Berkeley Underground Scholars. Researchers conducted four focus groups comprised of 55 individuals.

Youth under the age of 18 and Latino residents are underrepresented in the focus groups. The qualitative data collected is also not necessarily representative of Black. Latino, formerly incarcerated, or housing-insecure residents.

Table 15. Focus Group Participants

Focus Group Description	Number of Participants
Black Residents	18
Housing- / Food-Insecure Residents	27
Black and Latin Youth	4
Justice-System-Impacted Students	6
Total Stakeholders	**55**

Focus group participants shared concerns regarding gang involvement, racism, and the availability of guns in Berkeley. Black and Latino youth and Justice-System-Impacted students expressed significant concerns about their personal safety and police violence. Participants identified homelessness and the housing crisis as critical public health and safety issues. Black residents, housing-insecure residents, and system-impacted individuals all expressed distrust in the city government. Black residents, youth, system-impacted students, and low-income residents also expressed that policing in Berkeley allows for race and income-related profiling. Focus group participants also stated that police resources are mismanaged.

Diverse perspectives were collected regarding the future role of BPD. Youth would like police officers who are part of the community and interact positively with young people. Participants who discussed divestment from police recommended investment in trained peacekeepers and community safety patrols as alternatives.

With regard to mental health crises and homelessness, focus group participants across demographic groups suggested that clinicians and social workers play a role in interventions. Focus group participants expressed broad support for the power of community-driven crime prevention strategies and expressed trust in community-based and faith-based organizations; conversely, there was some suspicion expressed regarding the idea that BPD functions would simply be performed by another government agency.

Relevance to NICJR's Recommended CERN

The proposed Tiered Dispatch model contemplates diverting 53 percent of non-criminal calls to a non-law enforcement response, which may comprise community-based providers, non-police City departments, or some combination of both. Survey and focus group results suggest a strong appetite and desire for, at a minimum, a supplemental response to many call types, including ones related to mental health, homelessess, and substance abuse; that supplemental response could be, for example, a community responder participating in call response, along with the BPD. This co-response model is reflected in CERN Tiers 2 and 3. CERN Tier 1 does not contemplate a joint law enforcement response, and NICJR does not recommend applying this co-response model to the non-criminal calls that are appropriate for a Tier 1 response.[17]

Some focus group participants expressed concern about another governmental, rather than community-based, entity, assuming BPD CFS responsibilities. This concern should be considered by the City when determining the final alternative response structure, specifically with respect to the scope and role of the planned SCU.

Conclusion

Berkeley is a relatively safe and well-resourced city. However, thefts, robberies, and incidents involving people with potential mental health and/or substance abuse challenges are of significant concern. By reducing BPD's focus on non-criminal and low-level CFS, the Department can improve its response, investigation, and prevention of more serious crime. A transition of responsibility for response to Tier 1 CFS should generate approximately $7.3 million annually in BPD budget savings. If invested in the build out of the alternative response network, these funds would comprise a 35 percent increase in the City Manager's proposed FY22 funding level for community-based organizations writ large. This type of targeted redirection of BPD resources would represent a significant and meaningful step in the City's efforts to reimagine public safety.

[17] The final survey questions as developed by the Task Force asked very directed questions - such as who should respond to specific call types - with very little contextual background or information. Further, these types of alternative response questions were only asked about certain call types: mental health, homelessness, and substance abuse, not the full array of non-criminal CFS.

Any reduction in policing services should be measured, responsible, and safe. Alternative responses should be piloted and scaled after proven effective. Members of the CERN – which should be robust, structured, well-trained, and professional teams – should have radio connection directly into BPD dispatch in order to be able to call for an officer if needed. Similarly, on Tier 2 calls, if officers are not needed, they should allow the CERN to remain on the call alone. During the pilot phase, how often the CERN request police assistance will have to be assessed and use that information to possibly move certain call types into different CERN levels. These new, reimagine ideas will take time and effort to implement successfully. More detailed recommendations on implementation measures will be included in the Final Report.

Appendix

NICJR will add this appendix prior to the Taskforce meeting on July 30 and re-submit the report

Appendix A

Original Call Type Description	Auditor Classification	NICJR Category Legend		
5 or More Unpaid Parking Tickets	N/A	Non-Criminal		**N/A Denotes call types not classified by the auditor**
5150 Transport	N/A	Non-Criminal		
Abandoned Vehicle	Traffic	Non-Criminal		
Advice	Community	Non-Criminal		
Aid to BFD	N/A	Non-Criminal		
Aid to Citizen	Community	Non-Criminal		
Animal Cruelty	FBI Part II Crimes	Misdemeanor		
Animal Matter	Community	Non-Criminal		
Annoying Phone Calls	Community	Non-Criminal		
Arson	Property Crime (FBI Part I Crime)	Serious Violent Felony		
Ascertain 911	Investigative/Operational	Non-Criminal		
Assault w/ Caustic Substance	Violent Crime (FBI Part I Crimes)	Serious Violent Felony		
Assault w/ Caustic Substance Report	N/A	Non-Criminal		
Assault w/ Deadly Weapon	Violent Crime (FBI Part I Crimes)	Serious Violent Felony		
Assault w/ Deadly Weapon Report	N/A	Non-Criminal		
Attempt Assault w/Deadly Weapon	N/A	Serious Violent Felony		
Attempted Rape	N/A	Serious Violent Felony		
Audible Alarm	Alarm	Non-Criminal		
Auto Burglary	Property Crime (FBI Part I Crime)	Non-Violent Felony		
Automatic Aid	N/A	Non-Criminal		
Bait Bike	N/A	Non-Criminal		
Barking Dog	Community	Non-Criminal		
Battery	FBI Part II Crimes	Serious Violent Felony		
Battery w/ grievous bodily harm (GBH)	Violent Crime (FBI Part I Crimes)	Serious Violent Felony		
Battery w/ grievous bodily harm (GBH) report	N/A	Non-Criminal		
Berkeley Municipal Code (BMC) Violation	FBI Part II Crimes	Non-Criminal		
Bike Stop	Traffic	Non-Criminal		
Bomb Threat	FBI Part II Crimes	Serious Violent Felony		
Brandishing	FBI Part II Crimes	Misdemeanor		
Burglary	Property Crime (FBI Part I Crime)	Non-Violent Felony		
Business & Professions Violation	FBI Part II Crimes	Non-Criminal		
Car Alarm	N/A	Non-Criminal		
Carbon Monoxide Alarm	N/A	Non-Criminal		
Carjacking	Violent Crime (FBI Part I Crimes)	Serious Violent Felony		

Original Call Type Description	Auditor Classification	NICJR Category Legend		
Child Abuse	FBI Part II Crimes	Serious Violent Felony		
Child Molest	Violent Crime (FBI Part I Crimes)	Serious Violent Felony		
Child Neglect	FBI Part II Crimes	Non-Criminal		
City Manager Report	Information/Administrative	Non-Criminal		
Civil Standby	Community	Non-Criminal		
Commercial Fire Alarm	N/A	Non-Criminal		
Construction Zone	N/A	Non-Criminal		
Court Order Report	Information/Administrative	Non-Criminal		
Court Order Violation	FBI Part II Crimes	Non-Violent Felony		
COVID-related, health and safety violation	N/A	Non-Criminal		
Dead Body Found	Medical or Mental health	Non-Criminal		
Defraud Hotel/Restaurant	FBI Part II Crimes	Misdemeanor		
Demonstration	Community	Non-Criminal		
Disturbance	FBI Part II Crimes	Non-Criminal		
Dog Bite	Community	Non-Criminal		
Drug Activity	FBI Part II Crimes	Non-Criminal		
DUI Driver	FBI Part II Crimes	Misdemeanor		
Expired Vehicle Registration	N/A	Non-Criminal		
Explosion	Community	Non-Criminal		
Extra Surveillance	N/A	Non-Criminal		
Fall On City Property	Information/Administrative	Non-Criminal		
Family Disturbance	FBI Part II Crimes	Non-Criminal		
Fire Alarm Reset	N/A	Non-Criminal		
Fire Information	N/A	Non-Criminal		
Firearm Destruction	Information/Administrative	Non-Criminal		
Foot Chase	FBI Part II Crimes	Misdemeanor		
Forged RX	FBI Part II Crimes	Non-Violent Felony		
Forgery	FBI Part II Crimes	Non-Violent Felony		
Found Juvenile	Community	Non-Criminal		
Found Person	Community	Non-Criminal		
Found Property	Community	Non-Criminal		
Gambling	FBI Part II Crimes	Misdemeanor		
GPS Tracker Alarm	Alarm	Non-Criminal		
Grand Theft	Property Crime (FBI Part I Crime)	Non-Violent Felony		

Original Call Type Description	Auditor Classification	NICJR Category Legend		
Hate Crimes	FBI Part II Crimes	Non-Violent Felony		
Hit & Run Non-Injury	Traffic	Misdemeanor		
Hit & Run w/ Injuries	Traffic	Serious Violent Felony		
Hit & Run w/ Injuries Report	N/A	Non-Criminal		
Home Invasion	Property Crime (FBI Part I Crime)	Serious Violent Felony		
Identity Fraud	FBI Part II Crimes	Misdemeanor		
Illegal Dumping	Community	Misdemeanor		
Indecent Exposure	FBI Part II Crimes	Misdemeanor		
Incorrigible	Community	Non-Criminal		
Information	Information/Administrative	Non-Criminal		
Injury Accident	Traffic	Non-Criminal		
Injury Accident Complaint of Pain	N/A	Non-Criminal		
Injury Accident Inv Ped or Bicyclist	N/A	Non-Criminal		
Injury Accident Report	N/A	Non-Criminal		
Inoperable Vehicle	N/A	Non-Criminal		
Kidnap	FBI Part II Crimes	Serious Violent Felony		
Knock & Talk	Investigative/Operational	Non-Criminal		
Lodging in Public	Community	Misdemeanor		
LoJack Stolen Car	Investigative/Operational	Non-Violent Felony		
Lost Property	Community	Non-Criminal		
Loud Report	Community	Non-Criminal		
Major Injury Accident	N/A	Non-Criminal		
Malicious Damage	N/A	Misdemeanor		
Medical Emergency	N/A	Non-Criminal		
Medical Emergency with Gun Shot	N/A	Non-Criminal		
Mental Health	N/A	Non-Criminal		
Mental Illness	Medical or Mental health	Non-Criminal		
Misc Penal Code Violation	FBI Part II Crimes	Non-Criminal		
Misc Vehicle Code Violation	Traffic	Non-Criminal		
Missing Juvenile	Community	Non-Criminal		
Missing Person	Community	Non-Criminal		
Missing Person at Risk	Community	Non-Criminal		
Mutual Aid Medical	N/A	Non-Criminal		
No Vehicle Identification	N/A	Non-Criminal		

Original Call Type Description	Auditor Classification	NICJR Category Legend		
Noise Disturbance	Community	Non-Criminal		
Non-Injury Accident	N/A	Non-Criminal		
Obstructing Traffic	N/A	Non-Criminal		
Officer Flagged Down	Community	Non-Criminal		
Oral Copulation	N/A	Serious Violent Felony		
Outside Agency Assist	Investigative/Operational	Non-Criminal		
Parking Violation	Traffic	Non-Criminal		
Pedestrian Stop	Traffic	Non-Criminal		
Peeper	N/A	Misdemeanor		
Person Calling For Help	N/A	Non-Criminal		
Person Down	Medical or Mental health	Non-Criminal		
Person w/ a Gun	FBI Part II Crimes	Non-Criminal		
Petty Theft	Property Crime (FBI Part I Crime)	Misdemeanor		
Possession of Stolen Property	FBI Part II Crimes	Misdemeanor		
Posted No Parking	N/A	Non-Criminal		
Priority Code Assist	N/A	Non-Criminal		
Pronet Alarm	Alarm	Non-Criminal		
Property Damage	Information/Administrative	Misdemeanor		
Prostitution	FBI Part II Crimes	Misdemeanor		
Prowler	FBI Part II Crimes	Misdemeanor		
Public Assist	N/A	Non-Criminal		
Rape	Violent Crime (FBI Part I Crimes)	Serious Violent Felony		
Reckless Driver	Traffic	Misdemeanor		
Red Zone Cite	N/A	Non-Criminal		
Repossession	Information/Administrative	Non-Criminal		
Residential Fire Alarm	N/A	Non-Criminal		
Robbery	Violent Crime (FBI Part I Crimes)	Serious Violent Felony		
Runaway	Community	Non-Criminal		
Search Warrant	Investigative/Operational	Non-Criminal		
Security Check	Community	Non-Criminal		
Service Agency Assist	N/A	Non-Criminal		
Sexual Assault	Violent Crime (FBI Part I Crimes)	Serious Violent Felony		
Sexual Battery	N/A	Serious Violent Felony		
Shooting Cold Report	N/A	Non-Criminal		

Original Call Type Description	Auditor Classification	NICJR Category Legend		
Shooting w/ Ambulance	N/A	Serious Violent Felony		
Shoplifter In-Custody	Property Crime (FBI Part I Crime)	Misdemeanor		
Shot At Dwelling	Violent Crime (FBI Part I Crimes)	Serious Violent Felony		
Silent Alarm	Alarm	Non-Criminal		
Speeding Vehicle	Traffic	Misdemeanor		
Spousal Abuse	FBI Part II Crimes	Serious Violent Felony		
Spousal Abuse w/o Injury	N/A	Misdemeanor		
Spousal or domestic abuse	FBI Part II Crimes	Serious Violent Felony		
Stolen Rental Vehicle	N/A	Non-Violent Felony		
Stolen Vehicle	Property Crime (FBI Part I Crime)	Non-Violent Felony		
Stolen Vehicle Recovery	Traffic	Non-Criminal		
Storm Log	N/A	Non-Criminal		
Subpoena Service	Information/Administrative	Non-Criminal		
Suicide Attempt	Medical or Mental health	Non-Criminal		
Suicide w/ Ambulance	Medical or Mental health	Non-Criminal		
Surveillance	Investigative/Operational	Non-Criminal		
Suspicious Circumstance	Community	Non-Criminal		
Suspicious Person	Community	Non-Criminal		
Suspicious Vehicle	Traffic	Non-Criminal		
Suspicious Vehicle	Community	Non-Criminal		
Temporary Restraining Order Log	Information/Administrative	Non-Criminal		
Temporary Restraining Order Violation	FBI Part II Crimes	Non-Violent Felony		
Test Call	N/A	Non-Criminal		
Threat of Suicide	Medical or Mental health	Non-Criminal		
Throwing Object(s) at Vehicle	FBI Part II Crimes	Misdemeanor		
Ticket Sign Off	N/A	Non-Criminal		
Traffic Stop	Traffic	Non-Criminal		
Traffic Hazard	Traffic	Non-Criminal		
Transportation	Traffic	Non-Criminal		
Trespassing	FBI Part II Crimes	Misdemeanor		
Under the Influence	N/A	Non-Criminal		
Unknown Injury Accident	Traffic	Non-Criminal		
Unknown Problem	Investigative/Operational	Non-Criminal		
Vandalism to Vehicle	FBI Part II Crimes	Misdemeanor		

Original Call Type Description	Auditor Classification	NICJR Category Legend		
Vehicle Blocking Driveway	N/A	Non-Criminal		
Vehicle Blocking Sidewalk	N/A	Non-Criminal		
Vehicle Double Parking	N/A	Non-Criminal		
Vehicle Pursuit	Traffic	Serious Violent Felony		
Vehicle Release	Traffic	Non-Criminal		
Vehicle Stop	N/A	Non-Criminal		
Vehicle vs Ped or Bike	N/A	Non-Criminal		
Vicious Dog	Community	Non-Criminal		
Video Alarm	N/A	Non-Criminal		
Vin Verification	Traffic	Non-Criminal		
Warrant Arrest	Investigative/Operational	Non-Criminal		
Welfare Check	Medical or Mental Health	Non-Criminal		
Wireless 911	Information/Administrative	Non-Criminal		

Appendix B

				* Highlighted cells indicate a change from Default CERN Assignment	* Highlighted cells indicate a change from Arrest Rate CERN Assignment
Call Type Code	**Call Type Description**	**NICJR Category**	**Default CERN C**	**Arrest Rate CERN Category**	**Alternate Response CERN Category**
111	Fire Information	NC	1	1	1
207	Kidnap	SV FEL	4	4	4
211	Robbery	SV FEL	4	4	4
215	Carjacking	SV FEL	4	4	4
220	Attempted Rape	SV FEL	4	4	4
242	Battery	SV FEL	4	4	3
243	Battery w/ grievous bodily harm (GBH)	SV FEL	4	4	4
244	Assault w/ Caustic Substance	SV FEL	4	4	4
245	Assault w/ Deadly Weapon	SV FEL	4	4	4
246	Shot At Dwelling	SV FEL	4	4	4
261	Rape	SV FEL	4	4	4
288	Child Molest	SV FEL	4	4	4
314	Incident Exposure	MISD	2	2	2
330	Gambling	MISD	2	2	2
415	Disturbance	NC	1	1	1
417	Brandishing	MISD	2	2	3
451	Arson	SV FEL	4	4	4
459	Burglary	NV FEL	3	3	3
470	Forgery	NV FEL	3	3	3
484	Petty Theft	MISD	2	2	2
487	Grand Theft	NV FEL	3	3	3
496	Possession of Stolen Property	MISD	2	2	2
537	Defraud Hotel/Restaurant	MISD	2	2	2
594	Malicious Damage	MISD	2	2	2
597	Animal Cruelty	MISD	2	2	2
601	Runaway	NC	3	3	1
1042	Welfare Check	NC	1	1	1
1053	Person Down	NC	1	1	1
1056	Suicide w/ Ambulance	NC	1	1	1
1057	Missing Person	NC	1	1	1

1067	Person Calling For Help	NC	1	1	1
1070	Prowler	MISD	2	2	3
1071	Shooting w/ Ambulance	SV FEL	4	4	4
1079	Bomb Threat	SV FEL	4	4	4
1080	Explosion	NC	3	3	3
1124	Abandoned Vehicle	NC	1	1	1
1148	Transportation	NC	1	1	1
1180	Major Injury Accident	NC	4	4	3
1181	Injury Accident	NC	4	4	3
1182	Non-Injury Accident	NC	4	4	3
1183	Unknown Injury Accident	NC	4	4	3
1194	Pedestrian Stop	NC	1	1	1
1196	Suspicious Vehicle	NC	1	1	1
1198	Priority Code Assist	NC	4	4	4
2430	Spousal Abuse w/o Injury	MISD	2	2	2
4390	Forged RX	NV FEL	3	3	3
5150	Mental Illness	NC	1	1	1
10851	Stolen Vehicle	NV FEL	3	3	3
10852	Vandalism to Vehicle	MISD	2	2	2
10855	Stolen Rental Vehicle	NV FEL	3	3	3
20001	Hit & Run w/ Injuries	SV FEL	4	4	4
20002	Hit & Run Non-Injury	MISD	2	2	2
23103	Reckless Driver	MISD	4	4	4
23109	Speeding Vehicle	MISD	2	2	1
23110	Throwing Object(s) at Vehicle	MISD	2	2	2
23152	DUI Driver	MISD	4	4	3
10 5	Posted No Parking	NC	1	1	1
1033A	Audible Alarm	NC	1	1	1
1033G	GPS Tracker Alarm	NC	1	4	3
1033S	Silent Alarm	NC	1	1	1
1033T	Pronet Alarm	NC	1	1	1
1033V	Video Alarm	NC	1	1	1
1056A	Suicide Attempt	NC	1	1	1

1056T	Threat of Suicide	NC	1	1	1
1057AR	Missing Person at Risk	NC	1	1	1
1057J	Missing Juvenile	NC	1	1	1
1062B	Civil Standby	NC	1	1	2
1071R	Shooting Cold Report	SV FEL	4	4	4
1091B	Barking Dog	NC	1	1	1
1091E	Dog Bite	NC	1	1	1
1091V	Vicious Dog	NC	1	1	1
1181C	Injury Accident Complaint of Pain	NC	4	4	1
1181P	Injury Accident Inv Ped or Bicyclist	NC	4	4	1
1181R	Injury Accident Report	NC	1	1	1
1194B	Bike Stop	NC	1	1	1
20001R	Hit & Run w/ Injuries Report	SV FEL	4	4	4
212 5	Home Invasion	SV FEL	4	4	4
22500E	Vehicle Blocking Driveway	NC	1	1	1
22500F	Vehicle Blocking Sidewalk	NC	1	1	1
22500H	Vehicle Double Parking	NC	1	1	1
22651I	5 or More Unpaid Parking Tickets	NC	1	1	1
22651J	No Vehicle Identification	NC	1	1	1
22651O	Expired Vehicle Registration	NC	1	1	1
22669D	Inoperable Vehicle	NC	1	1	1
243R	Battery w/ grievous bodily harm (GBH) rep	SV FEL	4	4	3
244R	Assault w/ Caustic Substance Report	SV FEL	4	4	3
245A	Attempt Assault w/Deadly Weapon	SV FEL	4	4	3
245R	Assault w/ Deadly Weapon Report	SV FEL	4	4	3
273 5	Spousal Abuse	SV FEL	4	4	3
273 5	Spousal or domestic abuse	SV FEL	4	4	3
273A	Child Abuse	SV FEL	4	4	3
288A	Oral Copulation	SV FEL	4	4	4
300WI	Child Neglect	NC	1	1	1
415E	Noise Disturbance	NC	1	1	1
415F	Family Disturbance	NC	1	1	1
459A	Auto Burglary	NV FEL	3	3	3

484C	Shoplifter In-Custody	MISD	2	4	3
530 5	Identity Fraud	MISD	2	2	2
601I	Incorrigible	NC	1	1	1
602L	Trespassing	MISD	2	2	2
647AB	Prostitution	MISD	2	2	2
647E	Lodging in Public	MISD	2	2	2
647F	Under the Influence	MISD	2	2	2
647I	Peeper	MISD	2	2	2
653M	Annoying Phone Calls	MISD	1	1	1
92D	Red Zone Cite	NC	1	1	1
92F	Obstructing Traffic	NC	1	1	1
92G	Construction Zone	NC	1	1	1
A911	Ascertain 911	NC	1	1	1
AA	Service Agency Assist	NC	4	4	4
ADVICE	Advice	NC	1	1	1
AID	Aid to Citizen	NC	1	1	1
AIDBFD	Aid to BFD	NC	4	4	4
ANIMAL	Animal Matter	NC	1	1	1
AUTOAID	Automatic Aid	NC	1	1	1
BAIT	Bait Bike	NC	4	4	4
BMCVIO	Berkeley Municipal Code (BMC) Violation	NC	1	1	1
BPVIO	Business & Professions Violation	NC	1	1	1
CAR	Car Alarm	NC	1	1	1
CM	City Manager Report	NC	1	1	1
CRTRPT	Court Order Report	NC	1	1	1
CRTVIO	Court Order Violation	NV FEL	3	3	3
DAMAGE	Property Damage	MISD	2	2	2
DBF	Dead Body Found	NC	3	3	3
DEMO	Demonstration	NC	1	1	1
DRUGS	Drug Activity	NC	1	1	1
EXSUR	Extra Surveillance	NC	4	4	4
FA-CO	Carbon Monoxide Alarm	NC	1	1	1
FA-COM	Commercial Fire Alarm	NC	1	1	1

FA-RES	Residential Fire Alarm	NC	1	1	1
FA-RST	Fire Alarm Reset	NC	1	1	1
FADEST	Firearm Destruction	NC	1	1	1
FALL	Fall On City Property	NC	1	1	1
FLAG	Officer Flagged Down	NC	4	4	4
FNDJUV	Found Juvenile	NC	1	1	1
FNDPER	Found Person	NC	1	1	1
FOOT	Foot Chase	MISD	2	2	3
FOUND	Found Property	NC	1	1	1
GUN	Person w/ a Gun	NC	4	4	3
HATE	Hate Crimes	NV FEL	3	3	3
HOT	Vehicle Pursuit	SV FEL	4	4	4
HSVIO	COVID-related, health and safety violation	NC	1	1	1
ILLDMP	Illegal Dumping	MISD	2	2	2
INFO	Information	NC	1	1	1
KNOCK	Knock & Talk	NC	4	4	3
LDRPT	Loud Report	NC	1	1	1
LJ	LoJack Stolen Car	NV FEL	3	3	3
LOST	Lost Property	NC	1	1	1
MED2	5150 Transport	NC	4	4	3
MEDICAL	Medical Emergency	NC	1	1	1
MEDICAL -GSW	Medical Emergency with Gun Shot	NC	3	3	3
MH	Mental Health	NC	3	3	1
MUTMED	Mutual Aid Medical	NC	1	1	1
NEW	Create New Call	NC	1	1	4
OUTAID	Outside Agency Assist	NC	4	4	4
PA	Public Assist	NC	1	1	1
PCVIO	Misc Penal Code Violation	NC	1	1	1
PRKVIO	Parking Violation	NC	1	1	1
RECOVR	Stolen Vehicle Recovery	NC	1	1	1
REG	No longer used	NC	1	1	1
REPO	Repossession	NC	1	1	1

SEARCH	Search Warrant	NC	4	4	4
SEC	Security Check	NC	1	1	1
STORML	Storm Log	NC	1	1	1
SUBP	Subpoena Service	NC	1	1	1
SURVE	Surveillance	NC	1	1	4
SUSCIR	Suspicious Circumstance	NC	1	1	1
SUSPER	Suspicious Person	NC	1	1	1
SUSVEH	Suspicious Vehicle	NC	1	1	1
T	Vehicle Stop	NC	4	4	1
TEST	Test Call	NC	1	1	1
TIX	Ticket Sign Off	NC	4	4	1
TRFHAZ	Traffic Hazard	NC	1	1	1
TROL	Temporary Restraining Order Log	NC	1	1	1
TROV	Temporary Restraining Order Violation	NV FEL	3	3	3
UNK	Unknown Problem	NC	1	1	1
VCVIO	Misc Vehicle Code Violation	NC	1	1	1
VEHPED	Vehicle vs Ped or Bike	NC	2	2	1
VREL	Vehicle Release	NC	1	1	1
VVER	Vin Verification	NC	1	1	1
W911	Wireless 911	NC	1	1	1
WARARR	Warrant Arrest	NC	4	4	3
XXSEXGRAB	sexual battery	SV FEL	4	4	3

Appendix C

CERN Tier 1 Sub-Category	Existing Contracted Community-Based Organizations
Administrative	None
Alarm	Downtown Ambassadors Street Team
Animal	Animal Rescue
Investigation	Downtown Ambassadors Street Team
Medical or Mental Health	Alameda County Network of Mental Health Clinics Bay Area Community Services Lifelong Medical Care Pacific Center for Human Growth Options Recovery Services- Detox Services & Day Treatment Berkeley Free Clinic The Suitcase Clinic
Municipal	
Public Order	Downtown Berkeley Associaton's Safety Ambassadors Program
Quality of Life	Bay Area Community Services Lifelong Medical Care Telegraph Business Improvement District Pacific Center for Human Growth Eden Information & Referral (211) Options Recovery Services- Detox Services & Day Treatment Berkeley Free Clinic Family Violence Law Center - Domestic Violence & Homelessness Prevention Project Downtown Berkeley Associaton's Safety Ambassadors Program

CERN Tier 1 Sub-Category	Existing Contracted Community-Based Organizations
Substance Use	Bay Area Community Services Lifelong Medical Care Telegraph Business Improvement District Pacific Center for Human Growth Eden Information & Referral (211) Options Recovery Services- Detox Services & Day Treatment Berkeley Free Clinic
Traffic	None
Other	None

Appendix D

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Friday, July 23, 2021 4:39 PM
To: Works-Wright, Jamie
Subject: FW: 7/30/2021 CALBHB/C Event: Vocational/MH Services

Please see the information below.

Jamie Works-Wright
Consumer Liaison
Jworks-wright@cityofberkeley.info
510-423-8365 cl
510-981-7721 office

From: Theresa Comstock <theresa.comstock@calbhbc.com>
Sent: Friday, July 23, 2021 2:31 PM
To: Works-Wright, Jamie <JWorks-Wright@cityofberkeley.info>; Grolnic-McClurg, Steven <SGrolnic-McClurg@cityofberkeley.info>; Margaret Fine <margaretcarolfine@gmail.com>
Subject: Re: 7/30/2021 CALBHB/C Event: Vocational/MH Services

Just a follow-up to make sure you received the invitation below. Please share with board/commission members and staff.

Best Regards,
Theresa Comstock, Executive Director
CA Association of Local Behavioral Health Boards & Commissions

_____

CALBHB/C Statewide Teleconference Invitation
July 30, 2021, 10:00 am - 11:30 am
Registration Link
(There is no fee to register.)

We invite you to join us for presentations and discussion regarding:

Vocational / Mental Health Services: Integrating Evidence-Based Programs

Employment is a major therapeutic tool, improving the quality of life and reducing symptoms in individuals with mild to moderate to severe mental illness.

Opening Remarks

- Department of Rehabilitation (DOR):
- *Joe Xavier, Director and Jessica Grove,*
- *Assistant Deputy Director Vocational Rehabilitation Employment Division*
- Department of Health Care Services (DHCS),
- *Jim Kooler, Dr.P.H., Assistant Deputy Director, Behavioral Health*
- Mental Health Services Oversight & Accountability Commission (MHSOAC),
- *Brian R. Sala, Ph.D., Deputy Director for Research and CIO*

Speaker Panel

- Alameda County Behavioral Health Care Vocational Services:
- *Chris Lorente, Individual Placement & Support (IPS) Trainer; Dawn Hanson,*
- *Rehabilitation Supervisor*
- Solano County Behavioral Health and Caminar, Inc.:

  Emery Cówan, LPCC, LMHC, Deputy Director, Behavioral Health
  Michael Schocket, Executive Director, Caminar Jobs Plus Program
  Yazmin Robledo, Individual Placement & Support (IPS) Supervisor, Caminar

- Calaveras County Mental Health Services,
- *Wendy Alt, LMFT, Deputy Director Behavioral Health and Betty Johnson,*
- *Employment Services Case Manager*

Discussion

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Friday, July 23, 2021 9:05 AM
To: Works-Wright, Jamie
Subject: FW: MHSA FY22 Annual Update Public Hearing Presentation
Attachments: MHSA FY22 Annual Update Public Hearing Presentation.ppt

Please see the presentation from Karen for the MHC meeting on July 22, 2021

Jamie Works-Wright
Consumer Liaison
Jworks-wright@cityofberkeley.info
510-423-8365 cl
510-981-7721 office

From: Klatt, Karen
Sent: Thursday, July 22, 2021 9:10 PM
To: Works-Wright, Jamie <JWorks-Wright@cityofberkeley.info>
Subject: MHSA FY22 Annual Update Public Hearing Presentation

Hi Jamie,

Attached you will find the MHSA FY22 Annual Update Public Hearing Presentation for the Commission.

Thanks,

Karen

Karen Klatt, MEd

MHSA Coordinator

City of Berkeley, Mental Health Division

3282 Adeline Street, Berkeley CA 94703

(510) 981-7644 – Office

(510) 849-7541 – Cell

KKlatt@cityofberkeley.info

Berkeley Mental Health
Mental Health Services Act (MHSA)
FY21/22 Annual Update
Public Hearing

1

MHSA Background

- Proposition 63 passed on November 2, 2004
- Became effective as statute, Mental Health Services Act (MHSA) on January 1, 2005
- 1% of personal income over $1 million
- Money is deposited into the MHSA Fund in the State Treasury
- Funds are to be used to expand and transform the Mental Health System.

2

Funding Components

- Community Services and Supports (CSS)
- Prevention and Early Intervention (PEI)
- Innovation (INN)
- Workforce Education and Training (WET)
- Capital Facilities and Technological Needs (CFTN)

3

MHSA Funding Distribution/Timelines

- Estimate local funds by State Estimates
- Funding distributed monthly based on deposits into MHSA Fund
- Monthly fund distribution fluctuates
- Three year timeframes to expend CSS, PEI and INN
- Five year timeframe to expend INN
- Use previous years unspent funds first

4

MHSA Plan Requirements

- Three Year Plans

- Annual Updates to the Three Year Plan

5

Steps to an Approved Plan

- Conduct a Community Planning Process that includes input from Consumers, Family Members and other MHSA Stakeholders.
- Write a Draft Plan
- Conduct a 30-Day Public Review
- Conduct a Public Hearing
- Obtain approval from City Council

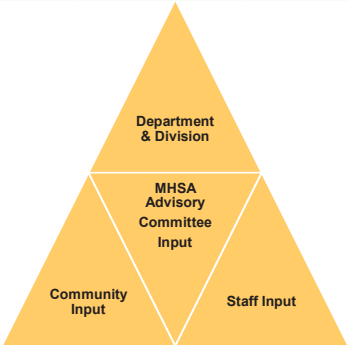
6

MHSA Plan Components

- Report on Community Planning Process
- Analysis of substantive comments received in 30-Day Public Review Period
- MHSA Funding Components (CSS, PEI, INN, WET, CFTN) will include:
  - Whether continuing services
  - Whether funding new services
  - Report on Program Data
  - Projected Program Expenditure Plan
    - Cost Per Person on CSS/PEI/INN Services
    - PEI and INN Evaluation Reports

7

Methodology for Three Year Plan Community Planning Process



8

MHSA FY22 Funding Projections

- All funding and expenditures throughout this presentation are based on projections of revenue and expenditures in FY22.
- The funding projections are based off of what was received in FY19 ($5,924,158).
- FY22 funding is projected to be approximately 43% higher than the amount received in FY19.

9

CURRENT Community Services & Supports (CSS) Programs/Services

***FULL SERVICE PARTNERSHIPS**

***MULTICULTURAL OUTREACH & ENGAGEMENT**

***SYSTEM DEVELOPMENT**

10

FULL SERVICE PARTNERSHIPS (FSP)

- **Children/Youth Intensive Supports Program**

  -Provides intensive short-term, individualized treatment, care coordination, and support to children and youth.

TAY, Adult & Older Adult Program

-Provides intensive support services to individuals with severe mental illness using an Assertive Community Treatment approach.

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FULL SERVICE PARTNERSHIPS *(CONT).*

- **Homeless Outreach Full Service Partnership:** This FSP provides wrap-around services to individuals who are homeless and experiencing mental health needs.

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MULTICULTURAL OUTREACH & ENGAGEMENT

- **Diversity & Multicultural Services**

The Division's Diversity and Multicultural Coordinator provides leadership in identifying, developing, implementing, monitoring, and evaluating services and strategies that lead to continuous cultural, ethnic and linguistic improvements within the organizations system of care.

13

MULTICULTURAL OUTREACH & ENGAGEMENT

- **Transition Age Youth Support Services**

-Provides outreach, supports, services and/or referrals to Transition Age Youth with serious mental health issues who are homeless and not currently receiving services.

14

SYSTEM DEVELOPMENT

- **Wellness & Recovery Support Services**

-Involves the inclusion of staff, stakeholders and consumers working together to advance Wellness & Recovery goals on a system wide level.

- **Family Support Services**

-Provides support and linkages to services for family members of BMH consumers and other community members in need.

- **Housing Supports**
- **Benefits Advocacy Services**

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SYSTEM DEVELOPMENT *(Continued)*

- Increased hours of service for the Mobile Crisis Team (MCT)
- Transitional Outreach Team (TOT)
- Flex funds for other levels of care
- Mental Health Wellness Center in Berkeley (in collaboration with Alameda County).
- Sub-rep payee services for consumers of Berkeley Mental Health
- Case Management Services for Transition Age Youth
- Funds to support additional services for Asian Pacific Islanders

16

Proposed Additions Through CSS Funds

17

Proposed Additions Through CSS Funds

- **Expansion of Peer Staff:** Allocate $321,993 to add two staff with lived experience as mental health peers, to the Wellness and Recovery Team. This proposal comes out of desire to increase the provision of peer driven services and reduce the use of security guards in the mental health setting.
- **Increase budget and add flexibility for Substance Use Disorder services:** Add $100,003 (for a total amount of $250,000) to enable additional funding and flexibility for Substance Use Disorder services.

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Proposed Additions Through CSS Funds (cont.)

•**Increase funds for Russell Street Residence:** Allocate $47,716 of additional funding to cover costs in FY21 and FY22 due to a rent increase.

•**Allocate funds for the Specialized Care Unit:** Allocate a one-time amount of $132,000 of CSS funds to be used to leverage other City funds for this pilot program. The total amount of proposed MHSA funds is $200,000 ($132,000 from CSS, and $68,000 from PEI). This is a one time request, as the City of Berkeley determines how to best fund this Specialized Care Unit.

•**Increase funds for McKinley House for Permanent Housing for FSP Clients:** Add $40,000 of CSS funds to cover the costs for operating the McKinley House site and subsidies in FY21 and FY22. Following FY22, the ongoing amount will be $120,000 on an annual basis.

19

CSS PROJECTED FUNDS

FY21/22
$6,595,582

20

CSS FY21/22 PROJECTED FUNDS

Estimated FY21/22 Funds:	$6,595,582
Estimated Unspent Funds:	+$6,310,561
	$12,906,143

21

Proposed Additions Through CSS Funds

Program	Proposed Additions	Proposed Costs
Peer Staff	-Two Support Services Specialists and non-personnel	$321,993
Substance Use Disorder Staffing/Programming	-Add funding and flexibility to Substance Use Disorder Staffing/Programming	$100,003
Russell Street Residence	-Increase funds for Board & Care	$47,716
Specialized Care Unit (SCU)	-Provide a one-time amount to be used to support the SCU	$132,000
McKinley House	-Add funds for operations and subsidies	$40,000
TOTAL		**$641,712**

22

CSS FY21/22 TOTAL PROJECTED EXPENDITURES

Program	FY21/22
Children's FSP	$680,239
TAY, Adult & Older Adult FSP	$2,689,827
Homeless FSP	$1,176,437
Multi-Cultural Outreach & Engagement (Incl. TAY Support Svcs.)	$456,040
System Development (Incl. Wellness Recovery, Family Advocacy, Housing Supports, Benefits Advocacy, Housing Co., Vocational Co., Rep. Payee Services, Flex Pay, Youth Case Management Services, FIT, Wellness Center, clerical and compliance staff, and proposed new additions)	$2,838,693
Crisis (Inclu. Transitional Outreach Team)	$194,653
Administration	$665,594
TOTAL ESTIMATED EXPENDITURES FY21/22	$8,701,483

23

CSS FY21/22 FUNDS

Total Estimated Funds	**$12,906,143**
Est. FY21/22 Expenditures:	- $8,701,483
	$4,204,660

24

Current Prevention & Early Intervention (PEI) Programs/Services

One in four people has a mental illness.
You can be the one that helps.

25

BE A STAR Project

- Coordinated system in Berkeley to identify children age 0-5 at risk of developmental delay, and social/emotional/behavioral concerns.
- Triage, assessment, referral, and treatment to community based or specialist services for children who are screened positive.

26

Child & Youth Risk Prevention Project

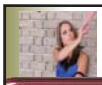
This project provides early childhood mental health case consultations, and interventions for teachers and parents to utilize to support individuals aged 0-5.

27

Supportive Schools Project

- Transforms school culture towards a *preventive, positive, and supportive* approach to managing problem behavior.
- Provides individual and group mental health services for children in need.

28



Additional School Projects

•High School Youth Prevention Project: Provides mental health services and supports at Berkeley High and B-Tech for youth who are experiencing various stressors.

•Mental and Emotional Education Team (MEET): Trains student peers to conduct class presentations on common mental health disorders, area resources, and basic coping and intervention skills.

•Dynamic Mindfulness (DMind) Project: An evidence based intervention that integrates mindful action, breathing, and centering into classroom and afterschool sessions.

29

Additional School Supports (cont.)

African American Success Project

•Project in BUSD middle school for students and their families to actively engage in the classroom and school life while creating a pathway for long-term success.

30

Social Inclusion Project

- Anti-Stigma Project, "Telling Your Story".
- Consumer and family member–led education effort.
- Consumer presentations to schools and community organizations to dispel myths, attitudes, and discrimination around mental health clients and issues.

31

Community Education/Supports

- Program Components
  - ❖Outreach & Engagement
  - ❖Support Groups
  - ❖Community Education
  - ❖Building Leaders
  - ❖Consultation/Training

Target Groups: • AA • Latinos • LGBTQIA+ • Older Adults • TAY

32

California Mental Health Services Authority (CalMHSA)

A State Joint Powers Authority that provides local resources on:

- Suicide Prevention
- Student Mental Health
- Stigma and Discrimination

33

Proposed Additions Through PEI funds

- **Allocate funds for the Specialized Care Unit:** Allocate a one-time amount of **$68,000 – sixty-eight thousand** of PEI Funds for the Specialized Care Unit.
- **Allocate funds for a Mental Health Promotion Campaign:** Dedicate $100,000 of one-time funds for a community Mental Health Promotion Campaign to support wellness and self-care.
- **Increase funds for the Supportive Schools Project:** Allocate an additional $110,000 a year for increased mental health supports for students.

34

PEI PROJECTED FUNDS

FY21/22
$1,648,896

35

PEI FY21/22 PROJECTED FUNDS

Estimated FY21/22 Funds:	$1,648,896
Estimated Unspent Funds:	+ $1,885,708
Total Estimated Funds	**$3,534,604**

36

Proposed Additions Through PEI Funds

Program	Proposed Additions	Proposed New Costs
Specialized Care Unit	-Provide a one-time funding amount to be used to support the (SCU)	$68,000
Mental Health Promotion Campaign	-Provide a one-time funding amount to be used for a Mental Health Promotion Campaign	$100,000
Increase funding for the Supportive Schools Project	-Provide increase to current amount of $55,000 for mental health supports for students for total amount of $110,000	$55,000
TOTAL		**$223,000**

37

PEI FY21/22 PROJECTED EXPENDITURES

Program	FY21/22
Be A Star	$27,903
Child & Youth Risk Prevention Project	$34,364
BUSD School Projects (Incl. Supportive Schools Project, DMIND, Mental Health Peer Education Project, African American Success Project)	$445,000
High School Youth Prevention Project	$516,368
Social Inclusion	$9,000
Community Education & Supports	$364,092
CalMHSA Program Contribution	$65,956
Specialized Care Unit	$68,000
Mental Health Promotion Campaign	$100,000
Administration	$282,221
TOTAL	**$1,912,904**

38

PEI FY21/22 FUNDS

Total Funds **$3,534,604**
Est. FY21/22 Expenditures: - $1,912,904
$1,621,700

39

Current Innovations (INN) Programs/Services

40

Help@Hand Project

(formerly named Technology Suite)

Will implement technology-based mental health services and solutions (mobile and computer applications - Apps) that can be accessed by community members on an at-will, voluntary basis.

•To assess whether an App that would assist individuals in recognizing signs and symptoms of mental health concerns, would promote better mental health outcomes;

•To assess whether the provision of technology-based services would increase access to mental health services.

41

Proposed Additions in FY22 through INN funds

- New Wellness Center Project for Homeless Encampments
- This project is undergoing a separate process.

42

INN PROJECTED FUNDS

FY21/22
$433,920

43

INN FY21/22 PROJECTED FUNDS

Estimated FY21/22 Funds:	$433,920
Estimated Unspent Funds:	$1,387,243
Total Estimated Funds	**$1,821,163**

44

INN FY22 PROJECTED EXPENDITURES

PROGRAM	FY22 PROJECTED EXPENDITURES
Help@Hand Project	$66,500
New Homeless Wellness Project	$560,000
TOTAL	$626,500

45

INN FY21/22 FUNDS

Total Funds	**$1,821,163**
Est. FY21/22 Expenditures:	- $626,500
	$1,194,663

46

WORKFORCE, EDUCATION & TRAINING (WET)

47

REGIONAL PARTNERSHIP

- Student Loan Repayment Program – Through the Greater Bay Area Workforce, Education and Training Regional Partnership
  $40,157

48

Capital Facilities & Technological Needs (CFTN)

49

Adult Clinic Renovation

CFTN FUNDING

Adult Clinic Renovation

- If there are any remaining funds from the Adult Clinic Renovation in FY22, they will be utilized towards a plumbing project in the office building that is adjacent to the Adult Clinic.
- Potential amount of remaining funds - $189,599.

51

30 Day Public Review

Public Comments

No Public Comments received.

52

NEXT STEPS

- Obtain approval from City Council
- Submit approved plan to the Department of Health Care Services (DHCS) and the Mental Health Oversight and Accountability Commission (MHSOAC)

53

COMMENTS/QUESTIONS

54

CONTACT INFORMATION & RESOURCES

MHSA Coordinator
Karen Klatt, M.Ed.
(510) 849-7541
(510) 981-7644
KKlatt@cityofberkeley.info

City of Berkeley MHSA Website
www.ci.berkeley.ca.us/mentalhealth
*(follow link to MHSA webpage)

55

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Wednesday, July 21, 2021 1:38 PM
To: Works-Wright, Jamie
Cc: Grolnic-McClurg, Steven; Warhuus, Lisa
Subject: FW: Division of Mental Health Client Records and Community Health Records for Alameda County

Please see the email below from Margaret, MHC Chair.

Thank you for your time.

Jamie Works-Wright
Consumer Liaison & Mental Health Commission Secretary
City of Berkeley
1521 University
Berkeley, CA 94703
Jworks-wright@cityofberkeley.info
Office: 510-981-7721 ext. 7721
Cell #: 510-423-8365

From: Margaret Fine <margaretcarolfine@gmail.com>
Sent: Wednesday, July 21, 2021 1:27 PM
To: Works-Wright, Jamie <JWorks-Wright@cityofberkeley.info>
Subject: Division of Mental Health Client Records and Community Health Records for Alameda County

Hi Jamie,

Would you please kindly forward this email to the Mental Health Commissioners and send a copy to the Mental Health Division Manager and the Director of Health, Housing and Community Services? It is much appreciated. Thank you!

Dear Commissioners,

I would like to kindly ask for your attention to pp. 208-226 in the Agenda Packet (link below) and the information below on the data available for client service delivery from the Community Health Records for Alameda County.

The pages reflect the forms used for client assessments and service delivery at the Division of Mental Health for the City of Berkeley. They are key to understanding the level of information available to clinicians, case managers and additional

staff in order to provide services to clients. Please note the level of detail required for demographic reporting. Overall the forms contain service history, assessments, and treatment plans from the Division of Mental Health.

Per the Mental Health Manager's Report, it is also noted when an open client receives a service from another Alameda County Behavioral Health provider (hospital, sub-acute residential, treatment team, psychiatry) that information is also available. All clinical staff have access and use Clinician's Gateway on a regular basis. The Mental Health Division Manager will be present at the meeting so we can ask further questions.

Here is the link—scroll down to July, 2021 for this packet, then go to page 208:

https://www.cityofberkeley.info/Clerk/Commissions/Commissions__Mental_Health_Commission_Homepage.aspx

As a follow up to our presentation last month, there is information below about the type of electronic information available in the Community Health Records from multiple systems, and information about how frequently they are updated. This information should, hopefully, assist in informing our discussion for Thursday night.

Community Health Records – information available

1. Care Team Members and Social Contacts can coordinate across multiple systems

2. Medi-Cal coverage status and health plan data

3. Clinical encounters, programs, providers, diagnoses, and assigned primary care medical home

- Alameda Health System – all outpatient clinics – real time

4. Mental Health services (including John George and crisis response), programs and utilization

- John George Hospital – real time
- Emergency Medical Services – real time
- Alameda County Behavioral Health – updated weekly

5. Detailed hospital info including discharge summaries

- Alameda Health System, including Highland, San Leandro, Alameda Hospitals – real time
- Sutter Campus and Eden Hospital – real time

5. Housing programs and Coordinated Entry System information from HMIS

- Homeless Management Information System (HMIS) – updated daily

6. Current Santa Rita incarceration – updated hourly

7. Public benefit information from social services agencies, including CalWorks, CalFresh, General Assistance, and Medi-Cal Re-enrollment due date – updated twice monthly

I will look forward to discussing these records this Thursday at our Mental Health Commission meeting at 7 pm.

Best wishes,
Margaret

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Tuesday, July 20, 2021 9:37 AM
To: Works-Wright, Jamie
Subject: FW: MHSA Annual Update - Funding for Programs and Staff Positions
Attachments: Division of MH Org Chart Explainer w COB HR Job Descriptions.zip; Division of Mental Health Organizational Chart 84 FTE.docx; MHSA FY21 & FY22 Projected Expenditures by Program Chart July 2021.pdf; MHSA Annual Update FY22 Funding for Expenditures.pdf

Please see the email from Margaret, MHC Chair

Jamie Works-Wright
Consumer Liaison
Jworks-wright@cityofberkeley.info
510-423-8365 cl
510-981-7721 office

From: Margaret Fine <margaretcarolfine@gmail.com>
Sent: Tuesday, July 20, 2021 9:09 AM
To: Works-Wright, Jamie <JWorks-Wright@cityofberkeley.info>
Subject: MHSA Annual Update - Funding for Programs and Staff Positions

Hi Jamie,

Would you kindly send this email to the Commissioners? Thank you so much.

Hi All,

As mentioned yesterday, we have the public hearing on the MHSA Annual Update FY22 this Thursday. The public hearing is a good opportunity to ask questions about funding, programs and staffing.

Last month the Mental Health Division Manager provided the organizational chart. The staff chart by program is below and attached. Also attached are the City of Berkeley, Human Resources job descriptions in case you may want to look at job duties.

In addition there is an updated chart attached with the MHSA funded staff positions (or part of a full-time position) for FY22. The MHSA Coordinator, Karen Klatt, who will be presenting this Thursday updated this chart.

I have further attached the MHSA Annual Update Report FY 22, which is organization by program and discusses the role of staff, so you can easily access the Annual Update

Best wishes,
Margaret

Margaret Fine
Cell: 510-919-4309

DIVISION OF MENTAL HEALTH for the CITY OF BERKELEY

Division Manager of Mental Health Services

ADULT SERVICES
Adult Mental Health Program Supervisor – reports to Division Manager

Adult FSP - Full Service Partnership Program (highest level) – 71 clients, $4,886 avg month
FSP Mental Health Clinical Supervisor

- 2 FSP BHC (Behavioral Health Clinician) II
- 2 FSP BHCII – vacant
- 2 FSP BHC I
- FSP Social Services Specialist p

Adult CCT - Comprehensive Community Treatment Program (2nd highest) 175 clients, $2,023 month
CCT Mental Health Clinical Supervisor

- CCT Lead Behavioral Health Clinician (BHC)
- 6 CCT BHC II

- CCT BHC II – vacant
- CCT BHC I
- CCT Assistant Mental Health Clinician - vacant

Adult FIT - Flexible Integrated Treatment Program (step-down), 100 clients, 4/21, $1,143

FIT Mental Health Clinical Supervisor

- FIT BHC II
- FIT Community Health Worker Specialist

Adult Services

- Housing Social Services Specialist p
- FSP/CCT Office Specialist II
- Vocational Social Services Specialist p – vacant
- SUDI Substance Use Disorder, Social Services Specialist p – vacant

FYC – FAMILY, YOUTH & CHILDREN'S SERVICES
Mental Health Program Supervisor – reports to Division Manager of MH Services

- Lead Behavioral Health Clinician
  - BHCII
  - BHC II Triage (temp)
  - BHS BHC II – vacant

FYC Children's FSP - Full Service Partnership Program, 9 clients, $4,970 avg monthly

- Children's FSP Lead Behavioral Health Clinician – vacant
  - Children's FSP BHCII
  - Children's FSP Social Services Specialist p

BFYC Mental Health Clinical Supervisor, 51 clients, £1,785

- FYC BHCII
- FYC BHCII (.5 FTE) – vacant

- FYC BHC II
- FYC BHC II

MEDICAL STAFF – reports to Division Manager of Mental Health Services
Supervising Psychiatrist

- Adult Mental Health Nurse (MHN)
- Adult MHN – vacant
- Adult MHN – hourly
- Adult Office Specialist II
- CCT Psychiatrist
- FSP MHN – vacant
- J FSP MHN - .8 FTE
- FSP Psychiatrist - .75 FTE
- H FSP Psychiatrist - .5 FTE
- H FSP MHN

Crisis Services - CAT, MCT, HOTT, TOT
CAT - Crisis, Assessment & Triage (e.g. phone line)
MCT - Mobile Crisis Team
HOTT - Homeless Outreach Treatment Team
TOT - Transition Outreach Team

Mental Health Program Supervisor – all above programs – reports to Division Manager

- **Crisis Mental Health Clinical Supervisor – vacant**
- **May 2021: 61 phone incidents, 35 incidents field, 9 incidents home, 31 5150 evals, 7 holds leading to involuntary transport**
    - J Crisis BHCII
    - Crisis BHCII – vacant
    - Crisis BHCII
    - TOT BHCI
    - TOT Assistant Mental Health Clinician
    - Various Crisis BHCI/II
    - CAT/Crisis/HOTT Office Specialist II

- **CAT (proj) Mental Health Clinician Supervisor**

- CAT Lead Behavioral Health Clinician
- CAT Social Services Specialist p
- CAT (proj) Social Services Specialist p

- **HOTT FSP Mental Health Clinical Supervisor**
  - HOTT FSP Social Services Specialist p – vacant
  - HOTT FSP Social Services Specialist p
  - HOTT FSP BHCII – vacant
  - HOTT FSP BHCII

ADMINISTRATION

Assistant Manager of Mental Health Services

- **Program Support Office Specialist Supervisor**
  - Family, Children & Youth (FYC) Office Specialist III
  - Adult Office Specialist II
  - FYC/Adult Office Specialist II
  - Adult Office Specialist II
  - Division Office Specialist II

Assistant Manager of Mental Health Services

- **Compliance Officer/MHSA, Mental Health Program Supervisor**
  - Cultural Competency Training, Health Services Program Specialist
  - Operations Assistant Management Analyst
  - MHSA Community Services Specialist III
  - MHSA Assistant Management Analyst

  - CAMA - Compliance Assistant Management Analyst
  - CAMA - Compliance Assistant Management Analyst
  - Family Services Specialist, Community Health Worker Specialist
  - Consumer Liaison, Community Services Specialist II
  - Wellness Program, Assistant Management Health Clinician

MHSA FY22 Estimated Staffing/Costs and FY21 Projected Expenditures

Included are estimated FY22 staffing/costs and projected FY21 Expenditures that are attributed to the MHSA fund per each program and are comprised of personnel and non-personnel costs. The Division is continuing to work with Fiscal on the projected costs and expenditures. As such, if there are any changes to the FY22 costs listed below they will be reflected in the MHSA FY22 Annual Update, and the actual FY21 expenditures will be reflected in the FY20/21 Revenue and Expenditure Report.

Program	FY22 Staffing	Estimated FY22 Costs	Projected FY21 Expenditures
COMMUNITY SERVICES AND SUPPORTS (CSS)			
Children's FSP	1.0 Sr. Behavioral Health Clinician (Vacant) 1.0 FTE Social Services Specialist .50 BHC II (Vacant) .07 Community Health Work. Spec. .35 MH Program Supervisor .20 Office Specialist III	$680,239	$371,598
TAY, Adult & Older Adult FSP	2.0 BHC I 4.0 BHCII (2 Vacant) 1.0 MH Clinical Supervisor 1.0 MH Nurse .08 Community Health Worker Specialist 1.66 Psychiatrist .30 MH Program Supervisor .50 Office Specialist II 1.0 Social Services Specialist	$2,689,827	$2,062,385
Homeless FSP	1.0 MH Clinical Supervisor 1.0 MH Nurse (Vacant) 2.0 BHC II (Vacant) 1.0 Social Services Specialist .15 Psychiatric Supervisor	$1,176,437	$190,413

Program	FY22 Staffing	Estimated FY22 Costs	Projected FY21 Expenditures
Multicultural Outreach and Engagement	1.0 Health Services Program Specialist	$456,040	$327,762
System Development Crisis Transitional Outreach Team (TOT)	.55 MH Clinical Sup. (Vacant) .75 Assistant MH Clinician 1.0 BHC II (back-filled by a BHCI)	$194,653	$226,223
System Development Wellness Recovery (Incl. proposed additions in FY22 Annual Update)	1.0 Assistant MH Clinician 1.0 Community Services Specialist II Proposed Staff Additions in Annual Update: 2.0 Social Services Specialist	$587,302	$226,034
Other System Development (Incl. proposed additions in FY22 Annual Update)	1.65 OSII 2.0 Assistant Management Analyst .85 Social Services Specialist .70 Comm. Health Work Specialist -Proposed non-personnel additions in FY22 Annual Update: Increase funds for RSR and Substance Use Disorder Services, and provide one-time funding for Specialized Care Unit.	$2,251,391	$1,985,016

Program	FY22 Staffing	Estimated FY22 Costs	Projected FY21 Expenditures
CSS Administration	.60 Assistant Management Analyst .55 Community Services Specialist III .22 Assistant Mental Health Manager .22 Mental Health Manager .20 Mental Health Program Supervisor .35 Assistant Management Analyst .23 Associate Management Analyst .19 Administrative Fiscal Svcs. Manager	$665,594	$546,906
PREVENTION AND EARLY INTERVENTION (PEI)			
High School Youth Prevention Project	.80 Sr MHCS 1.46 BHC II .08 SrHSPS (Vacant) .46 HSPS (Vacant) .13 RN (Vacant)	$516,368	$349,278
Child/Youth At Risk	.20 BHC II	$34,364	$29,730
Be A Star	.21 Pub. H. Nurse - Vacant	$27,903	$27,903
Social Inclusion	NA	$9,000	0

Program	FY22 Staffing	Estimated FY22 Costs	Projected FY21 Expenditures
BUSD School Projects Supportive Schools MEET DMIND Af. Am. Success Project	NA	$110,000 $90,000 $95,000 $150,000	$55,000 $46,839 $95,000 $150,000
Community Education & Supports	NA	$364,092	$128,184
CalMHSA	NA	$65,956	$42,624
New Proposed Additions in MHSA FY22 Annual Update	N/A -Proposed non-personnel additions: Funding for Specialized Care Unit; Mental Health Promotion Campaign	$168,000	N/A
PEI Administration	.40 Assistant Management Analyst .45 Community Services Specialist III .11 Assistant Mental Health Manager .11 Mental Health Manager .11 Assistant Management Analyst .22 Mental Health Program Supervisor	$282,221	$248,835

Program	FY22 Staffing	Estimated FY22 Costs	Projected FY21 Expenditures
INNOVATIONS (INN)			
Help@Hand (Technology Suite Project)	NA	$66,500	$396,416
New INN Programs	NA	$560,000	0
WORKFORCE, EDUCATION & TRAINING (WET)			
Greater Bay Area Regional Partnership	NA	$40,157	0
CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN)			
Capital Facilities and Technological Needs	NA	$189,599	$9,973

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Monday, July 19, 2021 3:35 PM
To: Works-Wright, Jamie
Subject: FW: MHSA Annual Update FY 22 Public Hearing Info for the Thursday, Mental Health Commission meeting, 7 pm.
Attachments: Fact Sheet How Can the MHSA be Used to Support Individuals in the Criminal Justice System.pdf; Fact Sheet How Can the MHSA be Used to Support Homeless Individuals

Please see email below

Jamie Works-Wright
Consumer Liaison
Jworks-wright@cityofberkeley.info
510-423-8365 cl
510-981-7721 office

From: Margaret Fine <margaretcarolfine@gmail.com>
Sent: Monday, July 19, 2021 1:07 PM
To: Works-Wright, Jamie <JWorks-Wright@cityofberkeley.info>
Subject: MHSA Annual Update FY 22 Public Hearing Info for the Thursday, Mental Health Commission meeting, 7 pm.

Hi Jamie,

Would you kindly forward this general information to the Commissioners on the MHSA? I would like everyone to have this information for Thursday. Thank you so much.

Dear Commissioners,

As you may know, we will have our annual public hearing on the Mental Health Services Act (MHSA) Annual Update FY22 on Thursday, July 22, 2021 at 7 pm. The MHSA funding constitutes about 1/2 of the Division of Mental Health's yearly budget.

The Mental Health Commission has a state law mandate to hold an annual public hearing to approve the MHSA Annual Update FY 22 in order to submit it to the Berkeley City Council. The MHSA Annual Update is contained in your Agenda Packet for this month. There will be an opportunity to ask questions about the funding after the MHSA Coordinator, Karen Klatt, makes her presentation.

Here is some general information about the MHSA.

I have also attached two short papers on how MHSA funding can be used to address homelessness and for people with criminal-legal involvement, which may be of interest to you.

General Information on the MHSA

Mental Health Services Act (MHSA) generates about $2 billion per year of state funding from a 1% tax on people who earn over $1 million annually. There are 5 components to the MHSA:

Community Services and Support (CSS)

- This component is the largest of the MHSA components. Funding is used to provide direct services to TAY (transition age youth), adults and older adults with serious mental illness and children and youth with serious emotional disturbance. These direct services include the Full Service Partnership (FSP) Services for intensive outpatient services and overall general system development funding. There are screenshots below reflecting the Division of Mental Health's services as shown on its website.

Prevention and Early Intervention (PEI)

- The PEI component funds programs designed to prevent mental illness from becoming severe and disabling, with an emphasis on improving timely access to services for the underserved.

Innovation (INN)

- The INN component funds projects designed to test time-limited new or changing mental health practices that have not yet been demonstrated as effective. The purpose of the INN component is to infuse new, effective mental health approaches into the mental health system, particularly to increase access for underserved groups.

Capital Facilities and Technological Needs (CFTN)

- The CFTN component funds projects designed to enhance the infrastructure needed to support the behavioral health system, which includes improving or replacing existing technology systems and/or developing capital facilities to meet increased needs of the local mental health system.

Workforce Education and Training (WET)

- The WET component funds are used to fund programs designed to enhance the public mental health workforce.

State of California—Health and Human Services Agency
Department of Health Care Services

WILL LIGHTBOURNE
DIRECTOR

GAVIN NEWSOM
GOVERNOR

June 24, 2020

FACT SHEET

How Can MHSA Be Used To Support Individuals In The Criminal Justice System?

The Mental Health Services Act (MHSA) statute acknowledges that a system of care for individuals with severe mental illness is vital for successful management of mental health. It requires a comprehensive and coordinated system of care that includes criminal justice, employment, housing, public welfare, health, and mental health to address mental illness and deliver cost-effective programs.[1]

Counties may use MHSA funds for:

Diversion
"Funds may be used to provide services to persons who are participating in a presentencing or postsentencing diversion program".[2]

Parolees
"Funds may be used to provide services to persons […] who are on parole, probation, postrelease community supervision, or mandatory supervision".[3]

Discharge
"[T]he County may use MHSA funds for programs/services provided in juvenile halls and/or county jails only for the purpose of facilitating discharge".[4]

NOT in State/Federal Prisons
"Funds shall not be used to pay for persons incarcerated in state prison".[5]

Like any program funded through MHSA, the program must be set forth in the 3-year expenditure plan and annual update pursuant to W&I Code § 5847 and be vetted through a local stakeholder process.

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[1] Welfare & Institutions (W&I) Code § 5802.
[2] W&I Code § 5813.5(f).
[3] W&I Code § 5813.5(f).
[4] 9 California Code of Regulations (CCR) § 3610 (emphasis added).
[5] W&I Code § 5813.5(f); 9 CCR § 3610(f) includes federal prison (emphasis added).

Behavioral Health
1501 Capitol Avenue, MS 4000, P.O. Box 997413
Sacramento, CA 95899-7413
Phone: (916) 440-7800 Fax: (916) 319-8219
Internet Address: http://www.DHCS.ca.gov

Counties are authorized to fund the following programs under the **Community Services and Supports (CSS) Component** of MHSA:

MIOCR-like Programs
Counties shall consider and include program services similar to the Mentally Ill Offender Crime Reduction Grant Program (MIOCR) in the county plan and annual update.[6] MIOCR-funded projects include (but are not limited to):

- Individualized Treatment Plans
- Behavioral/Mental Health Assessments/Evaluations
- Intensive Case Management
- Substance Use Treatment
- Referrals and Linkages to Community Services
- Holistic Approaches/Wraparound Services
- Combination of Interventions
- Cognitive Behavioral Therapy
- Trauma-Informed Services
- Housing Assistance
- Life Skills
- Education
- Transportation
- Medication Management
- Psychiatric Services

Assisted Outpatient Treatment
When such programs are included in county plans, counties that elect to participate in the Assisted Outpatient Treatment Demonstration Project Act of 2002 may use MHSA funds for the provision of mental health services.[7]

No Place Like Home Program
W&I Code § 5849.1, expanded MHSA funds to cover the "No Place Like Home Program." Two billion dollars in bond proceeds are dedicated to invest in the development of permanent supportive housing for persons who are in need of mental health services and are experiencing homelessness, chronic homelessness, or who are at risk of chronic homelessness. "At-Risk of Chronic Homelessness" for this program means an adult or older adult, or a child with a serious mental disorder. This includes persons exiting institutionalized settings, such as jail or prison who were homeless prior to admission to the institutional setting. This also includes community crisis centers, prison, parole, jail or juvenile detention facility, or foster care. The bonds are repaid through funding from MHSA.

[6] W&I Code § 5813.5.
[7] W&I Code § 5813.5.

In addition to CSS programs, mental health in the criminal justice system can also be addressed by diversion efforts through the **Prevention and Early Intervention (PEI) Component** of MHSA:

> These programs emphasize strategies to reduce negative outcomes that may result from untreated mental illness, including but not limited to incarcerations.
>
> To this end, counties are directed to focus on:
> - Childhood trauma prevention and early intervention to deal with the early origins of mental health needs.
> - Early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention programming that occurs across the lifespan.
> - Youth outreach and engagement strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs.
> - Culturally competent and linguistically appropriate prevention and intervention.
> - Strategies targeting the mental health needs of older adults.

More Information on MIOCR: An Alternative Non-MHSA Resource

> The MIOCR was created and directed by the Board of Corrections (BOC), as specified in Penal Code (PC) § 6045, to administer grants to support prevention, intervention, supervision, and incarceration-based services and strategies to reduce recidivism and improve outcomes in California's mentally ill juvenile and adult offender populations.
>
> According to the Board of State and Community Correction (BSCC), a total of $18.8 million of Recidivism Reduction Funds was appropriated for local assistance MIOCR projects that were facilitated by 21 counties. MIOCR grants are being funded for three (3) years, and participating counties are mandated to create, at a minimum, a four-year local plan that include mental health treatment programs, practices, and strategies that have a demonstrated evidence foundation, and are appropriate and effective correctional interventions for the identified target population (BSCC.ca.gov).

MHSA funding can be versatile in its application to support individuals with mental health issues in the criminal justice system. It is important to remember that if a county is interested in using MHSA funding for such programs, every program must be reflected in the Three-Year Program and Expenditure Plan and annual update, and counties are required to partner with constituents and stakeholders throughout the planning and development process. The next county plan is due to the Mental Health Services Oversight & Accountability Commission and the Department of Health Care Services in FY 2020 and will cover FY 2020-2023.

State of California—Health and Human Services Agency
Department of Health Care Services

BRADLEY P. GILBERT, MD, MPP
DIRECTOR

GAVIN NEWSOM
GOVERNOR

March 23, 2020

FACT SHEET

How Can MHSA Be Used To Support Homeless Individuals?

MHSA statute acknowledges that a system of care for individuals with severe mental illness is vital for successful management of mental health. It requires a comprehensive and coordinated system of care that includes criminal justice, employment, housing, public welfare, health, and mental health to address mental illness and deliver cost-effective programs.[1]

Like any program funded through MHSA, the program must be set forth in the 3-year expenditure plan and annual update pursuant to W&I Code § 5847 and be vetted through a local stakeholder process.

MHSA funded services and assistance are available to persons who are homeless or at risk of being homeless, who are also suffering from serious mental illness.[2]

Counties are authorized to fund services to the homeless and housing assistance through the **Community Services and Supports (CSS), Prevention and Early Intervention (PEI), Innovation (INN), and Capital Facilities and Technological Needs (CF/TN) components** of MHSA.

CSS Programs

CSS is the largest MHSA component at 76% of county MHSA funding.[3] CSS funds may be used to serve the homeless population through the following services and programs.

Full Service Partnership (FSP)
Counties are required to direct a majority of their CSS funds to FSPs.[4] Individuals eligible for an FSP include those who are unserved or underserved and may be homeless or at risk of becoming homeless.[5] FSPs

[1] Welfare & Institutions (W&I) Code § 5802.
[2] W&I Code §§ 5600.3(b)(4)(A) and 5600.4(j).
[3] California Code of Regulations (CCR) § 3420; W&I Code § 5892(a)(5)).
[4] CCR § 3620(c).
[5] CCR § 3620.05(b)(c)(d).

Behavioral Health
1501 Capitol Avenue, MS 4000, P.O. Box 997413
Sacramento, CA 95899-7413
Phone: (916) 440-7800 Fax: (916) 319-8219
Internet Address: http://www.DHCS.ca.gov

provide wrap-around or "whatever it takes" services to clients. FSP mental health services and supports[6] include:

- Mental Health Treatment
- Supportive Services to Assist the Individual in Obtaining and Maintaining Employment, Housing and/or Education.
- Peer Support
- Wellness Centers.
- Personal Service Coordination/Case Management
- Needs Assessment
- Individual Services and Supports Plan (ISSP) Development
- Crisis Intervention/Stabilization Services
- Family Education and Reunification Services

FSP non-mental health services and supports[7] include:

- Food
- Clothing
- Housing, including, but not limited to:
    - Rent Subsidies
    - Housing Vouchers
    - House Payments
    - Residence in a Drug/Alcohol Rehabilitation Program
    - Transitional and Temporary Housing
- Cost of Health Care Treatment
- Cost of Treatment of Co-Occurring Conditions, such as Substance Abuse
- Respite Care

General System Development (GSD) Programs

CSS funds can also be used to fund GSD programs, which may include mental health treatment, peer support, and personal service coordination. Such programs could include assistance in accessing housing and crisis intervention/stabilization services.[8] Examples of such programs include:

- Countywide housing specialist teams that provide housing placement services.
- Crisis teams that provide linkage to county mental health programs.

Additionally, under GSD, a county may transfer funds to their local government housing entity for a specific Project-Based Housing Program.[9] Examples of Project Based Housing include:

- Rehabilitation of a hotel for short-term housing.
- Purchase of a house for transitional housing.
- Construction of a building for master leasing of units.

[6] CCR § 3620(a)(1)(A).
[7] CCR § 3620(a)(1)(A).
[8] CCR § 3630(b).
[9] CCR § 3630.05(a).

Outreach and Engagement (O&E)
CSS can be used to fund outreach activities/programs that are intended to identify unserved individuals who meet certain criteria[10], in order to engage them in the mental health system so that they receive the appropriate services.[11]

- O&E funds may pay for food, clothing, and shelter, *but only when* the purpose is to engage unserved individuals, and when appropriate their families, in the mental health system. Examples:
  - Multi-Disciplinary Teams that Engage Homeless
  - Peer Services
  - TAY Targeted Teams
  - Navigators
- O&E activities include:
  - Outreach to entities such as schools, tribal communities, public places such as streets and trails, jails and hospitals.
  - Outreach to individuals who are homeless and those who are incarcerated in county facilities.

Housing Assistance
CSS funds may be used for "housing assistance"[12] which includes:

- Rental assistance or capitalized operating subsidies.
- Security deposits, utility deposits, or other move-in cost assistance.
- Utility payments.
- Moving cost assistance.
- Capital funding to build or rehabilitate housing for homeless, mentally ill persons or mentally ill persons who are at risk of being homeless.[13]
- Housing may include short-term housing (ex. hotel), transitional and permanent supportive housing.

No Place Like Home (NPLH) MHSA-Funded Supportive Services
NPLH funding is a separate funding source from MHSA, but to get the funding through NPLH, an applicant county has to commit to providing the NPLH tenant population mental health supportive services for at least 20 years. They can use multiple funding sources to provide the supportive services, including MHSA funding. The NPLH program is dedicated to the development of permanent supportive housing for persons who are in need of mental health services and are experiencing homelessness, chronic homelessness, or who are at risk of chronic homelessness. Under this program, counties can use the money awarded them to fund housing, and subsidize extremely low rent levels. If a county is awarded NPLH funding, then the program requires

[10] W&I Code § 5600.3 (criteria).
[11] CCR § 3640(a).
[12] W&I Code § 5892(a)(5).
[13] W&I Code § 5892.5.

the following mandatory supportive services (which can be funded through MHSA) to be provided to NPLH tenants[14]:

- Case management.
- Peer support activities.
- Mental health care, such as assessment, crisis counseling, individual and group therapy, and peer support groups.
- Substance use disorder services, such as treatment, relapse prevention, and peer support groups.
- Support in linking to physical health care, including access to routine and preventive health and dental care, medication management, and wellness services.
- Benefits counseling and advocacy, including assistance in accessing SSI/SSP, and enrolling in Medi-Cal.
- Basic housing retention skills (such as unit maintenance and upkeep, cooking, laundry, and money management).

And the following services to be made available and encouraged[15]:

- Services for persons with co-occurring mental and physical disabilities or co-occurring mental health and substance use disorders not listed above.
- Recreational and social activities.
- Educational services, including assessment, GED, school enrollment, assistance accessing higher education benefits and grants, and assistance in obtaining reasonable accommodations in the education process.
- Employment services, such as supported employment, job readiness, job skills training, job placement, and retention services, or programs promoting volunteer opportunities for those unable to work.
- Obtaining access to other needed services, such as civil legal services, or access to food and clothing.

MHSA Housing Program

This program provided funding for the capital costs and operating subsidies to develop permanent supportive housing for individuals with serious mental illness who are homeless, or at risk of homelessness. In 2016 the MHSA Housing Program was replaced with the Local Government Special Needs Housing Program (SNHP), which was intended to be a bridge between the MHSA Housing Program and NPLH. Effective January 3, 2020, the California Housing and Finance Agency (CalHFA) discontinued SNHP. While no longer in effect, this program:

- Created over 2,500 supportive housing units dedicated to individuals with serious mental illness.
- Used MHSA funds to leverage public, local, state, and federal funding to develop over 10,000 affordable housing units.

[14] NPLH Program Guidelines, pp 24-25.
[15] NPLH Program Guidelines, pp 25.

- For each dollar that MHSA provided, the federal government provided $4.50, private banks and non-profit organizations provided $3.50, locals provided $1.50, and the Housing and Community Development agency provided $1.

PEI Programs

PEI is the second largest component at 20% of a county's MHSA funding.[16] PEI programs emphasize strategies to reduce negative outcomes that may result from untreated mental illness, including, but not limited to, prolonged suffering and homelessness.[17] Some examples of PEI programs offering support to the homeless or at risk of being homeless are:

- **Landlord Outreach and Recruitment**
  These programs may prevent homelessness and build relationships that may lead to the availability of additional housing units. The county/provider acts as an intermediary by providing support to the tenant and conflict resolution assistance with the landlord.

- **Emancipating, Emancipated, and Homeless TAY Targeted Projects**
  These projects identify, support, treat, and minimize the impact for youth who may be in the early stages of a serious mental illness.

- **Wellness Centers**
  These centers provide recovery/supportive services for people with co-occurring conditions (mental, substance use or physical health conditions). This may include linkage to housing.

INN Projects

INN projects are funded with 5% of the total of CSS and PEI funds.[18] An INN project may affect virtually any aspect of mental health practices or assess a new or changed application of a promising approach to solving persistent, seemingly intractable mental health challenges, including, but not limited to, permanent supportive housing development.[19] A primary purpose of an INN project may be to:

- Increase access to underserved groups, which may include providing access through the provision of permanent supportive housing.[20]
- Support innovative approaches by participating in a housing program designed to stabilize a person's living situation while also providing supportive services on site.[21]

[16] W&I Code § 5892(a)(3).
[17] W&I Code § 5840(d).
[18] W&I Code § 5892(a)(6).
[19] W&I Code § 5830(c)(9).
[20] W&I Code § 5830(b)(1)(A).
[21] W&I Code § 5830(b)(2)(D).

CF/TN Projects

A county may transfer CSS funds to the CF/TN component provided the transfer does not exceed 20 percent of the average amount of funds allocated to the county for the previous five fiscal years.[22] CF/TN projects are meant enhance the infrastructure needed to support implementation of MHSA, which includes improving or replacing existing technology systems and/or developing capital facilities to meet increased needs of the local mental health system. All plans for proposed facilities with restrictive settings must demonstrate that the needs of the people to be served cannot be met in a less restrictive or more integrated setting, such as permanent supportive housing.[23] Examples include homeless shelters and navigation centers.

MHSA funding can be versatile in its application to assist individuals with mental health issues at risk for homelessness or experiencing homelessness. It is important to remember that if a county is interested in using MHSA funding for such programs, every program must be reflected in the Three-Year Program and Expenditure Plan and annual update, and counties are required to partner with constituents and stakeholders throughout the planning and development process. The next county plan is due to the Mental Health Services Oversight & Accountability Commission (MHOAC) and the Department of Health Care Services (DHCS) in FY 2020 and will cover FY 2020-2023.

[22] W&I Code §5892(b).
[23] W&I Code § 5847(b)(5).

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Monday, July 19, 2021 8:48 AM
To: Works-Wright, Jamie
Subject: FW: Mental Health Advisory Board Meeting - July 19, 2021
Attachments: 2021 07-19 MHAB Agenda - Final.pdf; MHAB Bylaws CURRENT.pdf; MHAB Bylaws Memo 01.11.2021.pdf; MHAB Bylaws Memo 07.16.2021.pdf; MHAB 2021 Amended Bylaws DRAFT 07.16.2021.pdf; MHAB Annual Report July 2021 (Draft).pdf; MHAB Meet the Members.pdf

Hello Commissioners,

Please see the email below and attachments

Jamie Works-Wright
Consumer Liaison
Jworks-wright@cityofberkeley.info
510-423-8365 cl
510-981-7721 office

From: MHB Communications, ACBH <ACBH.MHBCommunications@acgov.org>
Sent: Friday, July 16, 2021 4:48 PM
Subject: Mental Health Advisory Board Meeting - July 19, 2021

Good afternoon,

Please see attached agenda and meeting materials for the MHAB meeting on Monday, July 19th.

Mental Health Advisory Board Meeting
Occurs the third Monday of every 1 month(s) from 3:00 PM to 5:00 PM

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Alameda County
Mental Health Advisory Board

Mental Health Advisory Board Agenda

Monday, July 19, 2021 ◊ 3:00 PM – 5:00 PM

This meeting will be conducted exclusively through videoconference and teleconference

https://global.gotomeeting.com/join/985234885

Teleconference: 1-571-317-3116, Access Code: 985-234-885

MHAB Members:	**Lee Davis** *(Chair, District 5)* **L.D. Louis** *(Vice Chair, District 4)* **Marsha McInnis** *(District 1)* **Kurtis Riener** *(District 2)* **Cicley Winston** *(District 2)*	**Lucy Hernandez** *(District 2)* **Warren Cushman** *(District 3)* **Loren Farrar** *(District 3)* **Ashlee Jemmott** *(District 3)* **Brian Bloom** *(District 4)*	**Jessie C. Slafter** *(District 4)* **Anh Thu Bui** *(District 5)* **Juliet Leftwich** *(District 5)* **Rebekah Kharrazi** *(BOS Rep., District 3)*

Committees

Adult Committee
Marsha McInnis, Chair

Children's Advisory Committee
L.D. Louis, Chair

Criminal Justice Committee
Brian Bloom, Co-Chair
Juliet Leftwich, Co-Chair

Quality Improvement Committee
Jessie C. Slafter

MHSA Stakeholders Committee
L.D. Louis

Measure A Oversight Committee
Vacant

MHAB Mission Statement

The Alameda County Mental Health Advisory Board has a commitment to ensure that the County's Behavioral Health Care Services provide quality care in treating members of the diverse community with dignity, courtesy and respect. This shall be accomplished through advocacy, education, review and evaluation of Alameda County's mental health needs.

3:00 PM Call to Order ---------- Chair Lee Davis

3:00 PM **I. Roll Call**

3:02 PM **II. Approval of Minutes**

3:05 PM **III. Chair's Report**
- A. New Member Introduction
- B. Annual Banquet

3:10 PM **IV. Director's Report**
- A. Brown Acted Body for Care First, Jails Last Resolution
- B. Budget Update
- C. General Department Update

3:40 PM **V. Committee Reports**
- A. Criminal Justice Committee
- B. Children's Advisory Committee
- C. Adult Committee
- D. MHSA Stakeholders Committee
- E. Quality Improvement Committee

3:55 PM **VI. Bylaws**

4:25 PM **VII. Annual Report**

4:55 PM **VIII. Public Comment**

5:00 PM **IX. Adjourn**

Contact the Mental Health Advisory Board at ACBH.MHBCommunications@acgov.org

MEMORANDUM

To: Alameda County Mental Health Advisory Board (MHAB)
From: Ad Hoc Bylaws Committee
Re: Proposed Amendments to MHAB Bylaws
Date: January 11, 2021

The Ad Hoc Bylaws Committee (Julie Leftwich, Marsha McInnis and Loren Farrar) has reviewed and analyzed the current bylaws of the MHAB, approved by the MHAB on May 9, 2016 and ratified by the Alameda County Board of Supervisors on September 26, 2017, together with relevant state and local law and the model bylaws published by the California Association of Local Behavioral Health Boards and Commissions. We have also consulted with Theresa Comstock, Executive Director of that Association.

The Ad Hoc Bylaws Committee accordingly recommends that the bylaws be amended in the following ways:

SUBSTANTIVE CHANGES

1. **Reduce the number of board members from 17 to 16.** Article I, Section IV(a), on p. 1 of the bylaws, states that the board shall have 17 members, one of whom shall be the Chair of the Board of Supervisors or his/her designee. Section 2.68.020 of the Alameda County Administrative Code states that the board shall consist of 17 members. Welfare and Institutions Code Section 5604(a)(1) states that boards shall have 10-15 members, but are permitted to increase that number. The model bylaws state that there shall be 15 members.

We recommend that the MHAB amend the bylaws to reduce the number of board members from 17 to 16, which will allow each supervisor to appoint three board members and the Chair of the Board of Supervisors to appoint his/her designee. The bylaws could also be amended to provide that in the event a motion receives a tie vote, the motion will fail. The Administrative Code Section should be amended to reflect any change in the number of board members.

2. **Amend the provisions regarding the composition of the board to reflect state law requirements and be less prescriptive about occupational representation on the board**. As set forth below, Article I, Section IV(c), on p. 2 of the bylaws, includes very specific requirements about board composition, e.g., that two members must be physicians engaged in private practice, one of whom shall specialize in psychiatry.

Welfare and Institutions Code Section 5604(a)(2)(B) states that: “Fifty percent of the board membership shall be consumers, or the parents, spouses, siblings, or adult children of

consumers, who are receiving or have received mental health services. At least 20% of the total membership shall be consumers, and at least 20% shall be families of consumers."

Section 5604(a)(2)(C) provides that:

> In addition to consumers and family members referenced in subparagraph (B), counties are encouraged to appoint individuals who have experience with and knowledge of the mental health system. This would include members of the community that engage with individuals living with mental illness in the course of daily operations, such as representatives of county offices of education, large and small businesses, hospitals, hospital districts, physicians practicing in emergency departments, city police chiefs, county sheriffs, and community and nonprofit service providers.

Finally, Section 5604.5(b) provides that mental health boards shall develop bylaws to be approved by the governing body which shall "ensure that the composition of the mental health board represents and reflects the diversity and demographics of the county as a whole, to the extent feasible."

Our bylaws don't include any of this state law language. The bylaws provide instead that:

> Board members shall be as follows: two members shall be physicians engaged in the private practice of medicine, one of whom shall specialize in psychiatry; nine members shall be persons representative of the public interest in mental health and of those nine, five shall be persons or the parents, spouse, or adult children of persons who have received mental health services; the other five members of the advisory board representative of the public interest shall be selected from the disciplines of psychology, social work, nursing, education, marriage and family counseling, psychiatric technology, criminal justice, hospital or community mental health facility administration and fiscal management.

Similar language is contained in Administrative Code Section 2.68.030.

We recommend that the MHAB revise the bylaws to reflect state law and add language to encourage, but not require, that certain professions (e.g., physicians in private practice and psychiatrists) be appointed to the board. The Administrative Code should be amended to reflect any changes in this regard.

3. **Add the state law consumer exception to the prohibition on board members who are employed by mental health services agencies.** Welfare and Institutions Code Sections 5604(e)(1) and (2) provide that no board member or spouse of a board member shall be employed by a county mental health service, by the State Department of Health Care Services or by the governing body of a mental health contract agency, unless that person is a consumer of mental health services and he/she holds a position which has no interest or influence regarding financial or contractual matters concerning that employer.

Article I, Section IV (c) and (f) of the MHAB bylaws, on p. 2, contain duplicative, but not identical, provisions prohibiting employment by mental health services agencies. They do not, however, include the consumer exception of state law. That exception should be added to the bylaws and this issue should only be addressed once.

4. **Reduce term limits for board members from 12 years to 9 years.** Article I, Section IV(e), on p. 2 of the bylaws, states that board members shall serve no more than 4 consecutive (3-year) terms, not to exceed 12 years total. Welfare and Institutions Code Section 5604(c) states that board members shall serve for a term of 3 years. The model bylaws state that board members shall be limited to 2 consecutive 3-year terms unless waived by a majority of the Board of Supervisors.

We recommend that the bylaws be amended to reduce board member terms to 3 consecutive 3-year terms.

5. **Eliminate the office of secretary.** Article I, Section VI, on p. 3 of the bylaws, states that there shall be a chair, vice-chair and secretary. Section X, also on p. 3, states that the secretary is responsible for confirming the accuracy of the minutes and shall assist the chair and vice-chair in the performance of their duties. The model bylaws, in contrast, state that board members shall serve as chair and vice-chair, and that the director of the county mental health services agency shall designate staff to serve as secretary for the board. We recommend that the bylaws be amended to be consistent with the model bylaws.

Section 2.68.050 of the Alameda County Administrative Code states that the board shall annually elect a chairman and if the chairman is absent from a meeting, the members who are present shall elect one member to serve as a temporary chairman. That section states further that the board may appoint a secretary who need not be a member of the board, to serve without compensation. The Administrative Code should be amended to reflect the bylaws and any changes thereto.

6. **Delete the requirement that committees develop annual work plans that are to be reviewed by the full board.** We recommend this requirement, set forth in Article I, Section XIV(h), on p.4, be deleted and that the bylaws be amended to require that the board hold an annual strategy meeting which includes a discussion of committee goals.

7. **Add provisions stating that standing committees must comply with the Brown Act and include at least 2 board members.** These provisions should be added to Section XIV, on p. 4.

8. **Clarify the role of committees.** Article I, Section XIV(h), on p. 4, states that "any action recommended by a committee shall be acted upon by the full" board. This language is vague and could be interpreted to require committees to obtain board approval for all of their actions (e.g., inviting speakers to meetings, etc.). The model bylaws do not contain anything on this topic.

We recommend that the MHAB delete this provision and add language stating that: 1) the function of a committee is to study an issue and advise the board; and 2) committees shall not make recommendations to the Board of Supervisors independently.

9. **Clarify the circumstances under which a board member may be removed from the MHAB.** Section XV(a), on p. 5, states that a board member may be removed after being absent at "three consecutive board and/or committee meetings… without just cause and advance notice of such cause prior to the meeting to be missed." Removal is also authorized for the circumstances outlined in Administrative Code Section 2.68.060 (providing that the Board of Supervisors may remove a board member in cases of misconduct, inability or willful neglect in the performance of his/her duties).

Because Section XV(a) does not specify to whom advance notice of an absence must be given, we recommend that it be amended to clarify that such notice must be provided to the chair and to staff designated by the Director of Behavioral Health Care Services to serve as secretary to the board. We also recommend that reference to "committee meetings" be deleted, so that removal is only appropriate where a board member has failed to attend three consecutive MHAB meetings without just cause and advance notice.

NONSUBSTANTIVE CHANGES

The Ad Hoc Committee also recommends that the bylaws be amended to make nonsubstantive changes (e.g., to remove duplicative provisions, change certain subject headings, etc.). Those changes will be reflected in the draft amended bylaws which will be provided to the board.

ALAMEDA COUNTY MENTAL HEALTH ADVISORY BOARD

BYLAWS

ARTICLE I

SECTION I - NAME

The name of this Board shall be the Alameda County Mental Health Advisory Board. "Board" shall reference the Mental Health Advisory Board, and the Board of Supervisors shall be referenced as such in full.

SECTION II - AUTHORITY AND PURPOSE

The authority of the Board is established by Welfare and Institutions Code Section 5604 et seq. In accordance with Welfare and Institutions Code Section 5604.2, the Board shall:

A. Review and evaluate the community's public mental health needs, services, facilities, and special problems in any facility within the county where mental health evaluations or services are provided, including, but not limited to, schools, emergency departments, and psychiatric facilities.

B. Review any county agreements entered into pursuant to Welfare and Institutions Code Section 5650 and make recommendations regarding concerns identified within those agreements.

C. Advise the Board of Supervisors and the Alameda County Behavioral Health Care Services Director as to any aspect of the local mental health program. The Board may request assistance from the local patients' rights advocates when reviewing and advising on mental health evaluations or services provided in public facilities with limited access.

D. Review and approve the procedures used to ensure citizen and professional involvement at all stages of the planning process. Involvement shall include individuals with lived experience of mental illness and their families, community members, advocacy organizations, and mental health professionals. It shall also include other professionals that interact with individuals living with mental illnesses on a daily basis, such as education, emergency services, employment, health care, housing, law enforcement, local business owners, social services, seniors, transportation, and veterans.

E. Submit an annual report to the Board of Supervisors on the needs and performance of the county's mental health system.

F. Review and make recommendations on applicants for the appointment of the Alameda County Behavioral Health Care Services Director. The Board shall be included in the selection process prior to the vote of the Board of Supervisors.

G. Review and comment on the county's performance outcome data and communicate its findings to the California Behavioral Health Planning Council.

H. Assess the impact of the realignment of services from the state to the county on services delivered to clients and on the local community.

I. Perform such additional duties as may be assigned to the Board by the Board of Supervisors.

SECTION III – RELATIONSHIP TO BOARD OF SUPERVISORS

The Board of Supervisors shall appoint members to the Board in accordance with Chapter 2.68 of the Alameda County Administrative Code and shall rely on the collective judgement of the Board for input on mental health-related issues.

SECTION IV – MEMBERSHIP

The Board shall be composed of 16 members, one of whom shall be the Chair of the Board of Supervisors or the Chair's designee. In accordance with Welfare and Institutions Code Section 5604:

A. The Board may recommend appointees to the Board of Supervisors. The Board's membership should reflect the diversity of the client population in Alameda County to the extent possible, and represent all geographic regions in the county and their demographics.

B. Fifty percent of the Board members shall be consumers, or the parents, spouses, siblings, or adult children of consumers, who are receiving or have received mental health services. At least 20 percent of the total membership shall be consumers, and at least 20 percent shall be families of consumers.

C. In addition to consumers and family members referenced in Paragraph B, the Board of Supervisors is encouraged to appoint individuals who have experience with and knowledge of the mental health system. This would include members of the community that engage with individuals living with mental illness in the course of daily operations, such as representatives of county offices of education, large and small businesses, hospitals, hospital districts, physicians practicing in emergency departments, city police chiefs, county sheriffs, and community and nonprofit service providers.

D. The term of each Board members shall be three years. The Board of Supervisors shall equitably stagger the appointments so that approximately one-third of the appointments expire in each year.

E. Except as provided in Paragraph F, a Board member or the member's spouse shall not be a full-time or part-time county employee of Alameda County Behavioral Health Care Services, an employee of the State Department of Health Care Services, or an employee of, or a paid member of the governing body of, a mental health contract agency.

F. A consumer of mental health services who has obtained employment with an employer described in Paragraph E and who holds a position in which the consumer does not have any interest, influence, or authority over any financial or contractual matter concerning the employer may be appointed to the Board. The member shall abstain from voting on any financial or contractual issue concerning the member's employer that may come before the Board.

G. Board members shall abstain from voting on any issue in which the member has a financial interest as defined in Section 87103 of the Government Code.

H. Board members shall reside in Alameda County. If it is not possible to secure membership as specified in this section from among persons who reside in the county, the Board of Supervisors may substitute representatives of the public interest in mental health who are not full-time or part-time employees of Alameda County Behavioral Health Care Services, the State Department of Health Care Services, or on the staff of, or a paid member of the governing body of, a mental health contract agency.

Board members shall not serve more than four consecutive terms. If prior to the expiration of a term of appointment a member ceases to retain the status which qualified such member for appointment to the Board, such membership shall terminate and there shall be a vacancy.

SECTION V - MEETINGS

Board meetings shall be subject to the provisions of Chapter 9 (commencing with Section 54950) of Part I of Division 2 of Title 5 of the Government Code, relating to meeting of local agencies (The Brown Act).

Regular meetings shall be held at least 10 times a year. Special meetings shall be convened at the request of the Chair or a majority of Board members and public notification of such meetings shall be sent at least 24 hours in advance of the meetings.

SECTION VI – OFFICERS

Board officers shall consist of a Chair and Vice-Chair. Officers shall serve for a term of two years, or until their successor is elected.

SECTION VII – ELECTION OF OFFICERS

A Nominating Committee shall be appointed by the Chair in July of each year. The Chair and Vice-Chair shall not sit as ex-officio members of the Nominating Committee. The Nominating Committee shall seek nominations and propose a slate of officers for the coming year, secure the verbal consent to serve of those nominated and report back to the Board in August. The Chair of the Nominating Committee shall assume the duties of the Board Chair to accept further nominations and conduct the election of officers during the August meeting.

SECTION VIII – TERMS OF OFFICE

New officers shall begin their terms on September 1 and serve for two years, or until their successor is elected. No member shall serve more than three consecutive terms in the same office.

SECTION IX – VACANCIES IN OFFICE

In the event during the Chair's term there is a vacancy in the office, the Vice-Chair shall become Chair for the remainder of the term. In the event during the Vice-Chair's term there is a vacancy in the office, the Board shall hold an election to fill the vacancy for the remainder of the term.

SECTION X – POWERS & RESPONSIBILITIES OF OFFICERS

The Board Chair shall be the principal executive officer and carry out the policies of the Board and the Executive Committee. The Chair shall prepare the agenda for and preside over all regular and special Board meetings, appoint Committee Chairs, and be in regular consultation with the Director of Behavioral Health Care Services.

The Vice-Chair shall assist the Chair in the performance of the Chair's duties. The Vice-Chair shall exercise all the powers of the Chair in the event of the Chair's absence.

SECTION XI – REMOVAL OF OFFICERS

An officer may be removed from office, for cause, by the majority vote of all members of the Board at an official Board meeting at which a quorum is present. Adequate formal notice, in writing and in person or by U.S. certified mail, must be given to any officer of such an impending removal action.

SECTION XII – VACANCIES

When a vacancy occurs, other than in an elective officer position, the Chair shall contact the Board of Supervisors to determine if there is a candidate for the vacancy and/or if the Board of Supervisors would consider recommendations from the Mental Health Advisory Board. All such vacancies shall be filled by appointment by the Board of Supervisors.

SECTION XIII – QUORUM

A quorum is one person more than one-half of the appointed members of the Board.

SECTION XIV – COMMITTEES

A. Committees shall be created as needed to do the work of the Board. Each Board member shall serve on at least one committee and/or serve as a Board liaison to another entity or organization.

B. The existing standing committees are the Executive Committee, which plans the Board agenda and may act on behalf of the Board under emergency circumstances or as directed by the majority of the Board; the Adult Committee; the Children's Committee; and the Criminal Justice Committee. Other standing committees may be created with the approval of the Board as needed to fulfill its statutory responsibilities.

C. The Executive Committee is composed of the Chair, Vice-Chair and Chairs of the standing committees of the Board. Any Board member may attend the Executive Committee meetings as a member of the public.

D. Each standing committee shall be chaired by a Board member and conducted in accordance with the Brown Act.

E. Ad hoc committees shall be created or dissolved by the Board Chair to reflect the Board's interests and responsibilities.

F. The Board Chair shall appoint the Chair of each standing and ad hoc committee. Board members may choose the committee upon which they wish to serve or shall be appointed to a committee or liaison role by the Board Chair. Committees must include at least two Board members, but may not include more than a quorum of the Board.

G. Committee goals will be discussed by the Board at its annual strategy meeting. The function of a committee is to study an issue and advise the Board of its findings and recommendation**s**. Committees shall not make recommendations directly to the Board of Supervisors.

H. The Chair may appoint a member of the Board as a liaison to another entity or organization to reflect the Board's interests and responsibilities.

I. The Chair, with the approval of the Board, may appoint a non-voting representative from another entity or organization to the Board to reflect the Board's interests and responsibilities not already represented by members appointed by the Board of Supervisors. Such a non-voting representative may provide reports or presentations to the Board at its meetings, in compliance with the Brown Act, and shall serve for a one-year term, subject to annual renewal by the Board.

SECTION XV – REMOVAL FROM THE BOARD

Board members shall contact the Chair and staff designated by the Director of Behavioral Health Care Services to serve as secretary to the Board prior to a meeting if they are unable to attend. Failure to do so will result in an unexcused absence. Absence at three consecutive Board meetings without just cause and advance notice shall be grounds for the Board to recommend removal of the member to the Board of Supervisors.

A Mental Health Advisory Board member may be removed by the Board of Supervisors in accordance with Section 2.68.060 of the Alameda County Administrative Code, which states: "In cases of misconduct, inability or willful neglect in the performance of his duties, any member may be removed by the affirmative vote of four members of the Board of Supervisors. Such member sought to be removed shall be given an opportunity to be heard in his own defense at a public hearing, and shall have the right to appear by counsel and to have process issued to compel the attendance of witnesses, who shall be required to give testimony, if such member of the advisory board so requests. A full and complete statement of the reasons for such removal, if such member be removed, together with the findings of fact made by the Board of Supervisors, shall be filed by the Board of Supervisors, with the County Clerk and made a matter of public record."

SECTION XVI – CONFLICT OF INTEREST

Appointments to the Board will be subject to state and federal conflict of interest laws.

SECTION XVII – RULES OF ORDER

Board meetings shall be conducted in accordance with the Brown Act, the Board bylaws, and Robert's Rules of Order to allow open participation. The Chair may also set discussion time limits as appropriate. If in conflict, the Brown Act will take precedence, followed by the Board bylaws, and then Robert's Rules of Order, respectively.

SECTION XVIII – EXPENSES

Pursuant to Welfare and Institutions Code Section 5604.3 and the Alameda County Administrative Code, the Board of Supervisors may pay from any available funds the actual and necessary expenses of the Board members incident to the performance of their official duties and functions. The expenses of Board members may include travel, lodging, child care, and meals for Board members while on official business as approved by the Behavioral Health Care Services Director and the Board, except that expenses related to travel outside of the Bay Area counties must be authorized by the Board of Supervisors pursuant to Section 2.68.080 of the Alameda County Administrative Code. A yearly finance report shall be presented to the Board so that expenses can be reviewed and approved.

Welfare and Institutions Code Section 5604.3 states further that: "Governing bodies are encouraged to provide a budget for the local mental health board, using planning and administrative revenues identified in subdivision (c) of Section 5892, that is sufficient to facilitate the purpose, duties, and responsibilities of the local mental health board."

ARTICLE II

SECTION I – AMENDMENTS TO THE BYLAWS

These bylaws may be amended by a two-thirds vote of the appointed membership during any Board meeting and adoption by the Board of Supervisors. The bylaws shall be reviewed periodically to ensure that they comply with state law and adequately address the needs of the Alameda County community.

SECTION II – EFFECTIVE DATE

Once approved by the Board, these bylaws shall be submitted to the Board of Supervisors for its approval and final adoption. The bylaws shall be effective concurrent with the effective date of an ordinance amending Chapter 2.68 of the Alameda County Administrative Code to make changes corresponding with the revisions in these bylaws.

These bylaws were approved by the Board on _____ and adopted by the Board of Supervisors on _____. The effective date of these bylaws is _____.

Signed:

_____
Lee Davis, Chair, Alameda County Mental Health Advisory Board

_____
L.D. Louis, Vice-Chair, Alameda County Mental Health Advisory Board

_____
Supervisor Keith Carson, President, Alameda County Board of Supervisors

Alameda County
Mental Health Advisory Board

Meet the Members of the Mental Health Advisory Board

Lee Davis, Chair
District 5

Lee Davis, a Civil Engineer and Journeyman Electrician by profession, comes to the work of the Alameda County Mental Health Advisory Board as a woman with lived experience of a mood disorder. Her recovery was supported by many local resources including John George and Fremont Hospital, Woodroe Place, and a stay in a licensed board and care. She recognizes how imperative each of these support systems were to her recovery and seeks to use her personal experience to help improve outcomes for others living with mood disorders or other mental health vulnerabilities. For more information on Lee's mental health journey visit the link:

https://medium.com/@leeandreadavis/being-bipolar-2950e86fab88

L.D. Louis, Vice Chair
District 4

L.D. graduated from Howard University in 1996 and UC Berkeley School of Law in 1999. She has been with the Alameda County District Attorney's Office for 21 years. During her tenure with the DA's office, she was assigned to the Domestic Violence Unit for 3 years. From 2009-2010, she was the co-leader of the Misdemeanor Trial Team in the Hayward Branch Office. For the last 11 years, L.D. has been assigned to the Mental Health Unit. This unit handles mostly involuntary civil commitments for Alameda County, including the Sexually Violent Predator cases, Mentally Disordered Offenders, Developmentally Delayed Persons, Persons Not Guilty by Reason of Insanity and Murphy Conservatorships. She also coordinated the District Attorney's Office working group on Collaborative Courts and Alternatives to Incarceration from 2017-2020. In August of 2018, L.D. was promoted to Assistant District Attorney and became head of the Mental Health Unit. In this new role, L.D. has worked on public policy and legislative issues and has provided testimony both for the California State Legislature and a Presidential Commission on Mental Health and the Law. L.D. has instructed others extensively on criminal defendant's mental competency, including a 4-part mental health webinar series for the California District Attorneys Association. In January 2020, L.D. planned and coordinated a 3-day state- wide training on Complex Mental Health Issues and the Law. She has also trained mental health professionals and attorneys regarding legal standards pertaining to Conservatorships and other forensic mental health topics. She is currently a technical advisor for the California District Attorneys Association in Mental Health & the Law. L.D. was President of the Bay Area Black Prosecutor's Association (2017-19) and has served on several boards including the Charles Houston Bar Association, the Earl Warren Inn of Court (past president) and the National Inns of Court Board. L.D. was appointed to the Alameda County Mental Health Advisory Board (MHAB) in 2017

by the Board of Supervisors and is currently Vice-Chair of the Board and currently chairs the MHAB Children's Committee.

Marsha McInnis
District 1

My family has many brain-based challenges from autism to schizophrenia. When I was in college, my academic direction toward biology and medicine changed to a career in the art field, which enabled me to help my oldest son when he was a toddler, as he was diagnosed with autistic spectrum disorder. As an artist, I could earn a living at home and work closely with therapeutic staff to aid in his progress. Currently, one of my other sons and a granddaughter live with serious psychiatric disorders.

I learned to become an advocate and utilized my professional skills through community involvement as payback for all the help given to my family. In 2005, I founded NAMI Tri-Valley, a non-profit that provides support, education, resource information and advocacy skills to residents in the Livermore, Dublin and Pleasanton area.

In 2003, I was accepted on the Alameda County Mental Health Board representing District 1 and served 4-years, mostly chairing the Board. Having a voice at the County table proved to be invaluable as I learned much about how a county behavioral health agency operated and the many different public policies. In 2018, I again was appointed on the Mental Health Advisory Board, this time to lend a voice from East County. As of 2021, I also serve on the NAMI Tri-Val-ley Board as Second Vice President and on the Board of Directors for the Alan Hu Foundation.

Cicley Winston
District 2

Cicley Winston has an A.S degree in Social and Behavioral Science and has been working with children, teens, and adults in the social and behavioral health field for over 25 years. She is a peer specialist, author and workshop facilitator and is genuinely passionate about seeking out resources and valuable information and engaging with the community to identify critical needs.

This research is collected and shared with others to assist in the process of identifying and connecting them with programs and services to help raise their awareness and quality of life. Through the National Association of Mental Illness (NAMI) Cicley has donated countless hours as a presenter in programs such as, In Our Voice, Law Enforcement Training and has been a participant in the Peer-to-Peer program. One of the many highlights in her career was owning and operating a successful preschool and wellness center for infants, toddlers, and schoolage children. Over the years, Cicley has obtained vast knowledge and experience in early childhood education, community organizing, business administration, mental health education and training, substance abuse education and youth development. Her vast knowledge and hands-on experience have prepared her to serve on Alameda Counties Mental Health advisory board with great honor and commitment.

Lucy Hernandez
District 2

Lucy Hernandez was born and raised in the Mission District of San Francisco before calling the East Bay home. Ms. Hernandez has over 20 years of administrative experience in the health care environment. She advocates for healthy living, higher education, and equality.

She currently serves as the Community Outreach Manager for Washington Hospital. Ms. Hernandez oversees the Hospital's community engagement programs and the Wellness Center. Her previous roles include executive assistant and managing a health resource library. Ms. Hernandez is an Ohlone College Alum with two Associates degrees in Administration of Justice and Social Science; she then graduated from Cal State Hayward with a bachelor degree in History with an emphasis in the History of California and the American Southwest; and in 2014 she received her Masters of Public Administration from Golden Gate University. In 2015 Ms. Hernandez was inducted into the Pi Alpha Alpha (PAA), the National Honor Society for Public Affairs and Administration. She also graduated from Leader- ship Fremont in 2016. In 2019, she became a member the American College Healthcare Executives. Ms. Hernandez is passionate in engaging her community by serving on the board of directors for Avanzando, Inc., Kids Breakfast Club (TKBC), Newark Chamber of Commerce, and Safe Alternatives of Violent Environment (SAVE). She is also a Rotarian with the Newark Rotary. In 2021, Ms. Hernandez was appointed to the Alameda County Mental Health Advisory Board. Her previous roles in the community include Ohlone College Puente Mentor, METAS Mentor (Newark Memorial High School); Past Com- missioner, City of Hayward Human Relations Commission and Alameda County Commission on the Status of Women; and Past Board of Director, Hispanic Community Affairs Council.

Kurtis Riener
District 2

Kurtis Riener is a transitional age youth consumer of mental health resources and is passionate about mental health and his community. Having dealt with mental illness first hand and knowing the impact it can make on a person's life, Kurtis have become increasingly vested in helping others who suffer in the same way. In pursuit of this goal, he facilitated multiple support groups in the community and is eager to make a difference on the Alameda County Mental Health Advisory Board. Outside of mental health, Kurtis is a graduate of James Logan High School and is currently attending Chabot College. He loves reading, hiking, and baking.

Ashlee Jemmott
District 3

Ashlee Jemmott has worked in the youth development and mental health field, providing resources, assistance, and guidance to multi-systems involving youth and young adults for the past 10 years. She is a certified Wellness Recovery Action Plan facilitator, Emotional Emancipation Circle Facilitator, and a Youth Mental Health First Aid Responder. Ashlee earned her Master's in Business Administration from the Lorry I Lokey Graduate School of Business, Mills College in Oakland California. Ashlee looks forward to using her lived experiences, and her education to create new, sustaining, and equitable partnerships to support the mental health community in Alameda County. Ashlee is a proud member of the Pool of Consumer Champion.

Loren Farrar
District 3

Loren Farrar is a Senior Program Administrator at First 5 Alameda County, where she oversees a large initiative designed to support prevention and early intervention related to early social-emotional (mental health) and developmental concerns in young children. Prior to working at First 5 Alameda County, she has worked in the social services and early childhood fields in both direct service and administrative positions. Loren has several immediate family members with mental health challenges and wants to work to ensure that Alameda County works to remove barriers to access to mental health prevention and treatment services, provide services through an equity lens, and increase focus on prevention and early intervention. Loren lives in San Leandro with her husband and two children.

Warren Cushman
District 3

Warren Cushman is a thirty-year advocate who acquired a mental illness in 2007. He is a consumer who is still navigating the effects of mental illness on those who suffer from it. His specialties include adult committee issues, housing, CalAIM and locked facilities. Warren is completely blind. He is a San Lorenzo resident and enjoys music, sports and outdoor dining.

Jessie Conradi Slafter
District 4

Jessie Conradi Slafter, A.S.W., J.D., is a Mental Health Attorney and Social Worker with East Bay Children's Law Offices and a partner on the statewide organization Parents & Caregivers for Wellness. Jessie provides specialty representation to foster youth who have profound mental health needs, are at risk of sexual exploitation, or who also have open delinquency cases. She brings a social work background, having practiced family therapy with delinquency youth for several years prior to attending law school. Jessie has worked with adolescents in various settings for over a decade and utilizes a trauma-informed approach to her representation, training, and relationships. Jessie is an Oakland native who is committed to promoting mental wellness for youth and families across Alameda County.

Brian Bloom
District 4

Brian Bloom has been a member of the Mental Health Advisory Board since 2014. He is one of Supervisor Nate Miley's appointees to the Board. He currently co-chairs the Board's Criminal Justice Committee. Brian represented the Board on the Justice Involved Mental Health Task Force in Alameda County from 2017 to the present. He was a High School Social Studies Teacher from 1984 to 1989. He recently retired as an Assistant Public Defender for the Office of the Alameda County Public Defender, having worked there for 27 years. He handled all manner of cases: from civil commitments to misdemeanors to complex capital litigation; supervised the Office's Training Program; was the Manager of various Branch Offices; and specialized in legal ethics as well as the interplay between criminal justice and mental health. Brian and his wife of 32 years live in Berkeley and have two adult children. He enjoys hiking, cooking, and playing guitar.

Dr. Anh Thu Bui
District 5

Dr. Bui came to the U.S. at age eleven as a refugee from Vietnam. She has worked as a community psychiatrist for more than twenty years. Much of her work in advocating for individuals with serious mental illness has been informed by witnessing trauma in her family and community. She graduated from UC San Diego with degrees in History and Animal Physiology andearned her Medical Degree from the Mayo Clinic School of Medicine. She holds board certifications in Psychiatry, Community and Public Psychiatry, and Addiction Medicine. Since 2015, she has served as Associate Medical Director of Psychiatry for LifeLong Medical Care, a Federally Qualified Health Center with several primary care clinics in the Bay area. She is currently a fellow at the California Health Care Foundation (CHCF) Health Care Leadership Program, since December 2019.

Juliet Leftwich
District 5

Juliet Leftwich has served on the Mental Health Advisory Board since 2018, representing District 5. She is Co-Chair of the Criminal Justice Committee, which has focused its efforts on reducing the Juliet Leftwich has served on the Mental Health Advisory Board since 2018, representing District 5. She is Co-Chair of the Criminal Justice Committee, which has focused its efforts on reducing the number of seriously mentally ill individuals at Santa Rita Jail and improving mental health care at the facility, as well as in the com- munity.

Ms. Leftwich is an attorney and the former Legal Director of the Giffords Law Center to Prevent Gun Violence, where she helped draft, enact and defend hundreds of state and local gun safety laws in California and nationwide. Since leaving the Law Center in 2017 to pursue her passion for other social and criminal justice issues, she has served on the Berkeley Police Review Commission and Berkeley Commission on the Status of Women, in addition to the Alameda County Mental Health Advisory Board. In June of 2021, the Berkeley City Council confirmed Ms. Leftwich's nomination to serve on the Berkeley Police Accountability Board, a new entity formed to succeed the Police Review Commission and strengthen its powers of oversight.

Rebekah Kharrazi
BOS Representative, District 3

Rebekah Kharrazi, MPH, CPH currently serves as a Senior Policy Advisor to Alameda County Supervisor Wilma Chan (District 3) overseeing health policy and legislation. Rebekah previously worked for the California Department of Public Health's Genetic Disease Screening Program, Oakland-based non-profit Prevention Institute, and as a Legislative Assistant to former California Governor Jerry Brown. She earned her Masters of Public Health from Columbia University's Mailman School of Public Health in Epidemiology with a certificate in Health Policy and Practice.

ALAMEDA COUNTY MENTAL HEALTH ADVISORY BOARD

BYLAWS

ARTICLE I

Section I **NAME**

The name of this organization shall be the Alameda County Mental Health Advisory Board.

Section II **DEFINITION AND PURPOSE (California Welfare & Institutions Code, Section 5604)**

a. Review and evaluate the Alameda County mental health needs, facilities, services and special problems.
b. Advise the County Board of Supervisors on any aspect of the local mental health programs.
c. Advise the Alameda County Mental Health Director on any aspect of the local mental health programs.
d. Review any county agreements or contracts entered into pursuant to Section 5650 of the Welfare and Institutions Code.
e. The Mental Health Advisory Board Chair shall submit an annual report at the end of each fiscal year to the County Board of Supervisors on the needs and performance of the county's mental health system.
f. Review and approve the procedures used to ensure citizen and professional involvement in all stages of the planning process.
g. Review and comment on the county's performance outcome data and communicate its findings to the California Mental Health Planning Council.
h. Review and make recommendations on applications for the appointment of a local director of mental health to the County Board of Supervisors. The board shall be included in the selection process prior to the vote of the governing body.
i. Pursuant to Welfare and Institutions Code Section 5604.2(b), the Mental Health Advisory Board shall assess the impact of the realignment of services from the state to the county, on services delivered to clients and the local community.
j. Perform any other duties requested by the County Board of Supervisors.
k. The Mental Health Advisory Board shall develop bylaws to be approved by the Board of Supervisors in accordance with Welfare and Institutions Code Section 5604.5.

Section III **RELATIONSHIP TO ALAMEDA COUNTY BOARD OF SUPERVISORS**

The Mental Health Advisory Board will be formalized by county ordinance. It is anticipated that the Board of Supervisors, by virtue of ordinance and appointment, shall rely on the collective judgment of the board and its members for input on all mental health related issues.

Section IV **MEMBERSHIP (Welfare and Institutions Code, Section 5604)**

a. The membership of the Mental Health Advisory Board shall be determined by the Board of Supervisors and established by ordinance. The Alameda County Mental Health Advisory Board will have 17 members, one of whom shall be the chairman of the Board of Supervisors or his or her designee. All members must be electors of the County.
b. The Mental Health Advisory Board membership should reflect the ethnic and cultural diversity of the client population in the county as a whole, and shall represent all geographic regions in the county and their demographics.

c. Board members shall be as follows: two members shall be physicians engaged in the private practice of medicine, one of whom shall specialize in psychiatry; nine members shall be persons representative of the public interest in mental health and of those nine, five shall be persons or the parents, spouse, or adult children of persons who have received mental health services; the other five members of the advisory board representative of the public interest shall be selected from the disciplines of psychology, social work, nursing, education, marriage and family counseling, psychiatric technology, criminal justice, hospital or community mental health facility administration and fiscal management. If prior to the expiration of a term of appointment a member ceases to retain the status which qualified such member for appointment on the advisory board, such membership on the advisory board shall terminate and there shall be a vacancy. No member of the advisory board or his or her spouse shall be a full-time or part-time employee of the Alameda County mental health service, an employee of the State Department of Health, an employee of the department of benefit payments, or an employee of a Short-Doyle contract facility.
d. The term of each member of the Mental Health Advisory Board shall be for three years. The Mental Health Advisory Board shall encourage the Board of Supervisors to equitably stagger the appointments so that approximately one-third of the appointments expire in each year.
e. Each Mental Health Advisory Board member shall serve no more than four consecutive terms and shall not exceed 12 years total. Mental Health Advisory Board staff shall keep a record of appointment for each board member.
f. No member of the Mental Health Advisory Board or his or her spouse shall be a full-time employee or part-time county employee of a county mental health service, an employee of the State Department of Mental Health, or an employee of, or paid member of, the governing body of a mental health contract agency.
g. Members of the Mental Health Advisory Board shall abstain from voting on any issues in which the member has financial interest as defined in Section 87100, et seq., of the California Government Code (Conflict of Interest).

Section V **MEETINGS (California Welfare and Institutions Code, Section 5604.1)**

Mental Health Boards shall be subject to the provisions of Chapter 9 (commencing with Section 54950) of Part I of Division 2 of Title 5 of the Government Code, relating to meeting of local agencies (The Brown Act).

In addition:

a. The place and time of the regular meetings is to be posted for the public according to the Brown Act and regular meetings shall be held at least 10 times each year. Meeting locations will be posted in accordance to the Brown Act .
b. Special meetings shall be convened in the following manner:

    1) Upon call of the chair or majority of board members, and
    2) In accordance with Government Code section 54956, the Brown Act, public notification shall be sent at least 24 hours in advance of the meeting.

Section VI **OFFICERS**

a. At the time of election of a chair there shall also be elected a vice-chair, and secretary.
b. The Executive Committee is composed of the chair, vice-chair, secretary, and chairs of the standing committees of the Mental Health Advisory Board . These meetings should be attended by appropriate mental health administration staff.
c. The officers shall serve for a term of one year, or until their successor is elected, and be subject to election in June of each year for terms beginning July 1 of each fiscal year.

Section VII **ELECTION OF OFFICERS**

a. A Nominating Committee shall be appointed by the chair in May of each year:
b. The chair, vice-chair, and secretary shall not sit as ex-officio members of the Nominating Committee.
c. The Nominating Committee sha ll:

1) Select a slate of officers for the coming year.
2) Secure the verbal consent to serve of those selected.
3) Report back to the full board in June with a slate of officers for the coming fiscal year (July 1 through June 30).
4) The chair of the Nominating Committee shall assume the duties of the Mental Health Advisory Board chair to accept further nominations and conduct the election of officers during the June meeting of the year.

Section VIII **TERMS OF OFFICE**

New officers shall begin their terms July 1 and serve for one year, ending June 30. No member shall hold more than three consecutive one-year terms in the same office.

Section IX **VACANCIES IN OFFICE**

In the event any officer resigns from his or her office or resigns from the Mental Health Advisory Board or is disqualified from serving due to a change in status during the term of his or her office, the board may hold an election to fill any vacancy occurring in any elective office during an unexpired term. In the event the chair resigns during his or her term, the vice-chair shall become chair.

Section X **POWERS & RESPONSIBILITIES OF OFFICERS**

a. The chair shall be the principal executive officer. He/she shall carry out the policies of this board and the Executive Committee. He/she shall carry out the purposes of this organization including consultation with the local mental health director (Welfare and Institutions Code Section 5604.S(d).
b. The vice-chair shall assist the chair in the performance of his/her duties. The vice-chair shall exercise all the powers of the chair in the event of the absence of the chair .
c. The secretary shall review the minutes of the Mental Health Advisory Board and Executive Committee prior to public distribution and is responsible for the accuracy of the minutes. The secretary shall assist the chair and vice-chair in the performance of their duties.

Section XI **REMOVAL OF OFFICERS**

a. An officer may be removed from office, for cause, by the majority vote of all members at an official board meeting at which a quorum is present.
b. Adequate formal notice, in writing and in person or by U.S. certified mail, must be given to any officer of such an impending removal action.

Section XII **VACANCIES**

When a vacancy occurs, other than in an elective officer position, the chair shall contact the Board of Supervisors to determine if there is a candidate for the vacancy and/or if the member would consider recommendations from the Mental Health Advisory Board. All such vacancies shall be filled by appointment by the appropriate County Supervisor.

Section XIII **QUORUM**

A quorum is one person more than one-half of the appointed members of the Mental Health Advisory Board.

Section XIV **COMMITTEES**

a. Committees shall be created as needed to do the work of the Mental Health Advisory Board. Standing committees will meet on a regular basis to develop and implement their work plans, which shall reflect current board goals and priorities.
b. Each member of the Mental Health Advisory Board shall serve on at least one committee and/or serve as a Mental Health Advisory Board liaison to another entity or organization.
c. The existing standing committees are the Executive Committee, which plans the board agenda and can act on behalf of the full board under emergency circumstances or as directed by the majority of the full board; the Adult Committee; the Children's Committee; and Criminal Justice Committee. The Executive Committee is composed of the chair, vice-chair, secretary, and chairs of the standing committees of the Mental Health Advisory Board. Any board member may attend the Executive Committee meetings as a member of the public.
d. Other standing committees shall function with the approval of the Mental Health Advisory Board and be approved by the Mental Health Advisory Board to conduct its business in accordance with its legal responsibilities and corresponding to the current membership of the Mental Health Advisory Board. Each standing committee shall be chaired by a Mental Health Advisory Board member.
e. Ad hoc committees shall be created or dissolved by the board chair to reflect the interest and responsibilities of the Mental Health Advisory Board.
f. Current liaison responsibilities shall be organized to reflect the interests and responsibilities of the Mental Health Advisory Board.
g. The chair of the Mental Health Advisory Board shall appoint the chair of each standing and ad hoc committee. Mental Health Advisory Board members may choose upon which committee they wish to serve, or shall be appointed to a committee or liaison role by the board chair . Committees may not consist of more than seven board members.
h. Committees shall develop annual work plans that will be reviewed by the full Mental Health Advisory Board . Any action recommended by a committee shall be acted upon by the full Mental Health Advisory Board.
i. The chair may appoint a member of the Mental Health Advisory Board as a liaison to another organization to reflect the interests and responsibilities of the Mental Health Advisory Board.
j. The chair, with the approval of the full Mental Health Advisory Board, may appoint a non-voting representative from another organization to reflect the interests and responsibilities

of the board not already represented by board members appointed by the Board of Supervisors. Such a non-member organizational representative may provide agendized reports or presentations to the board at its meetings, in compliance with the Brown Act .

Section XV REMOVAL FROM THE BOARD

a. Absence at three consecutive board and/or committee meetings, or for those circumstances outlined in Section 2.68.060 (Prior Admin. Code§ 5-19.06) of the Alameda County Administrative Code, without just cause and advance notice of such cause prior to the meeting to be missed, shall be grounds for summary removal of a Mental Health Advisory Board member. The chair will contact the Board of Supervisors in the event that removal is deemed necessary.
b. Section 2.68.060 of the Alameda County Administrative Code states: "In cases of misconduct, inability or willful neglect in the performance of his duties, any member may be removed by the affirmative vote of four members of the Board of Sup ervisors. Such member sought to be removed shall be given an opportunity to be heard in his own defense at a public hearing, and shall have the right to appear by counsel and to have process issued to compel the attendance of witnesses, who shall be required to give testimony, if such member of the advisory board so requests . A full and complete statement of the reasons for such removal, if such member be removed, together with the findings of fact made by the Board of Supervisors, shall be filed by the Board of Supervisors, with the County Clerk and made a matter of public record."

Section XVI CONFLICT OF INTEREST

Appointments will be subject to state and federal conflict of interest laws.

Section XVII RULES OF ORDER

Meetings of this board shall be conducted in accordance with the Brown Act, the Mental Health Advisory Board bylaws, and Roberts Rules of Order (Newly Revised) to allow open participation. The chair may also set discussion time limits as appropriate. If in conflict, the Brown Act will take precedence, followed by the Mental Health Advisory Board bylaws, and then Roberts Rules of Order, resp ectively.

Section XVIII EXPENSES

Pursuant to California Welfare and Institutions Code Section 5604.3 and the Alameda County Administrative Code (see below), the Board of Supervisors may pay from any available funds the actual and necessary expenses of the members of the mental health board of a community mental health service incurred incident to the performance of their official duties and function s. The expenses of Mental Health Advisory Board members may include travel, lodging, child care, and meals for Mental Health Advisory Board Members while on official business as approved by the Mental Health Director and the Mental Health Advisory Board. A yearly finance report shall be presented to the Mental Health Advisory Board so that expenses can be reviewed and approved.

California Welfare and Institutions Code 5604.3:
"The board of supervisors may pay from any available funds the actual and necessary expenses of the members of the mental health board of a community mental health service incurred incident to the performance of their official duties and functions . The expenses may include

travel, lodging, child care, and meals for the members of an advisory board while on official business as approved by the director of the local mental health program."

Alameda County Administrative Code 2.68.080 - Expenses:
"The members of the mental health advisory board shall serve without compensation and shall be reimbursed the actual amounts of their reasonable and necessary expenses incurred in attending meetings and in performing the duties of their office. Travel expenses shall be limited to mileage traveled within the Bay Area counties as defined in Chapter 3.36, Section 3.36.100 if this code, unless the board of supervisors specifically authorizes the travel beyond these counties."

ARTICLE II

Section I **AMENDMENTS**

These bylaws may be amended at any meeting of the Mental Health Advisory Board by a two-thirds vote of the appointed membership. These bylaws shall be reviewed periodically to ensure compliance with state law and adequately address the needs of our community.

Section II **EFFECTIVE DATE**

These bylaws shall become effective immediately upon their approval, and shall be submitted to the Board of Supervisors for their approval and final adoption.

The final draft was reviewed and endorsed by the Mental Health Advisory Board on May 9, 2016. They were then reviewed by County Counsel and the proposed revisions adopted on May 23, 2016. These articles were ratified by the Mental Health Advisory Board on September 12, 2016. They were ratified by the Alameda County Board of Supervisors on Septee0be(""..Aft 17

Signed:

Alane Friedrich

Alane Friedrich, Chair, Alameda County Mental Health Advisory Board

Jaseon Outlaw, Vice-Chair, Alameda County Mental Health Advisory Board

Supervisor Wilma Chan, President, Alameda County Board of Supervisors

To: Mental Health Advisory Board
From: Julie Leftwich
Re: Additional Recommendations for Bylaws Amendments
Date: July 16, 2021

The Ad Hoc Bylaws Committee and Executive Committee have the following additional recommendations for amendments to the bylaws:

1. **Board Member Terms.** Keep the provision limiting board member service to four consecutive terms, rather than changing it to three years as previously proposed, to encourage continuity of membership and recognize the value of institutional knowledge. (Section IV - Membership, last paragraph, p. 3.)

2. **Officer Terms.** Change officer terms from one year to two years for purposes of leadership training and continuity, despite the fact that this could potentially pose an issue if a person is elected officer in year two of his/her three-year board term and then doesn't continue on the board. (Section VI – Officers, p.3.)

3. **Officer Election Timeline.** Change the election timeline, which currently runs from May to July, to run from July to September. (Section VII – Election of Officers, Section VIII – Terms of Office, p. 3.)

4. **Term of Non-Voting MHAB Member.** Provide a one-year term for non-voting representatives from another entity or organization who may be appointed by the Chair, with the approval of the MHAB, to serve on the Board. The bylaws currently do not specify a term. (Section XIV(I) – Committees, p.5.)

5. **Bylaw Amendments.** The bylaws currently state that the bylaws "may be amended by a two-thirds vote of the appointed membership during any Board meeting." The Model Bylaws, in contrast, provide that amendments must be approved by "a two-thirds majority *of those in attendance at a regular or special meeting at which a quorum is present"*(emphasis added). The Model Bylaws, therefor, provide a much lower standard than what is currently in our bylaws, but still require a super majority vote. Should we change the bylaws to be consistent with the Model Bylaws? The Executive Committee had differing views on this issue. (Section I of Article II, p.6.)

Alameda County
Mental Health Advisory Board

Contact the Mental Health Advisory Board at:

ACBH.MHBCommunications@acgov.org

July 19, 2021

Alameda County Board of Supervisors
1221 Oak St., #536
Oakland, CA 94612

Re: MHAB Annual Report

Dear Alameda County Board of Supervisors,

The Alameda County Mental Health Advisory Board (MHAB) is pleased to provide this Annual Report for FY 2020-2021.

MHAB Statutory Authority and Duties

The authority of the MHAB is established by California Welfare and Institutions Code Section 5600 et seq. In accordance with Welfare and Institutions Code Section 5604.2, the MHAB is statutorily required, among other things, to:

- Review and evaluate the community's public mental health needs, services, facilities, and special problems in any facility within the county or jurisdiction where mental health evaluations or services are being provided, including, but not limited to, schools, emergency departments, and psychiatric facilities.
- Review any county agreements entered into pursuant to Welfare and Institutions Code Section 5650 and make recommendations regarding concerns identified within those agreements.
- Advise the Alameda County Board of Supervisors and the Alameda County Behavioral Health Care Services Director as to any aspect of the local mental health program.
- Review and approve the procedures used to ensure citizen and professional involvement at all stages of the planning process.
- Perform such additional duties as may be assigned to the Mental Health Advisory Board by the Alameda County Board of Supervisors.

Overview of MHAB Activities in FY 2020-2021

The MHAB worked diligently to carry out its duties over the last year, despite the challenges presented by the COVID-19 pandemic. The full MHAB held regular monthly meetings, as well as one special meeting and its annual strategy meeting/retreat**.** Regular monthly meetings were also held by the MHAB's Executive

Committee and its three standing committees: the Criminal Justice Committee, the Adult Committee and the Children's Committee. In addition, ad hoc committee meetings were held to: 1) update and draft proposed amendments to the MHAB bylaws; and 2) create a framework and monitoring structure for the MHAB to carry out its oversight duties.

In its advisory capacity, the MHAB sent correspondence to the Board of Supervisors:

- On April 24, 2020, expressing the MHAB's opposition to the $85 million request by the Sheriff and Health Care Service Agency for additional Santa Rita Jail staffing.
- On October 6, 2020, setting forth the MHAB's specific recommendations regarding actions the Board of Supervisors could take to reduce the number of seriously mentally ill individuals at the Jail.
- On March 3, 2021, opposing the proposed discontinuance of Intensive Outpatient Programs at Fairmont and Highland Hospital (this letter was sent to the Alameda Health System Board of Trustees, as well as to the Board of Supervisors).
- On June 17, 2021, expressing the MHAB's strong support for the "Care First, Jail Last" Resolution and urging the Board of Supervisors to reallocate half of the money previously earmarked for Santa Rita Jail and approve it instead for community-based treatment and housing that will reduce the number of mentally ill people who are incarcerated.

Copies of the correspondence are attached.

All MHAB meetings were held remotely, other than a meeting of a small group of MHAB members who participated in a guided tour of the facility formerly known as the Glenn E. Dyer Detention Facility. One of the MHAB recommendations to the Board of Supervisors of October 6, 2020, was that the building, which has been vacant for two years, be retrofitted and repurposed for use as a mental health treatment facility. We were pleased to learn that Behavioral Health Care Services has recommended that the GSA complete a feasibility study, and that the request has been sent to the Board of Supervisors for approval.

Summaries of MHAB committee activities are provided below.

<u>Criminal Justice Committee</u>
During the last year, the Criminal Justice Committee held monthly meetings, as well as one special meeting, focusing primarily on ways to implement the Board of Supervisors' directive to reduce the number of seriously mentally ill individuals at Santa Rita Jail. Discussion topics included, among other things, increased opportunities for diverting defendants out of the criminal justice system and into the appropriate level of community-based mental health treatment, addressing the deplorable treatment of mentally ill offenders at Santa Rita Jail, and the need for better discharge planning when defendants leave jail and re-enter the community.

To facilitate and inform these discussions, the Committee invited a variety of speakers to attend its meetings, including:

- Katie Kramer, from the Bridging Group, who spoke about the Safe Landing Project, a program that offers services to newly released inmates via a trailer that is parked outside of the jail;
- Dr. Lorenza Hall, Senior Management Analyst with ACBH Data Services**,** who presented data in response to the MHAB's November 2020 request for information about the population of mentally ill individuals at Santa Rita Jail;
- Juan Taizan, ACBH Forensic, Diversion and Re-Entry Director, who spoke about his background and vision for his new position;

- Dr. Aaron Chapman, ACBH's Medical Director and Chief Medical Officer, who spoke about the challenges in forming a definition of the term "seriously mentally ill," that would allow ACBH and the MHAB to objectively evaluate the effectiveness of efforts to reduce that population at Santa Rita Jail.

Criminal Justice Committee meetings were very well attended and included robust participation by a variety of groups, including family members, law enforcement representatives and mental health care providers.

Adult Committee

The MHAB Adult Committee reviews and discusses adult and/or older adult systems of care. Fiscal year 20/21 brought with it the precautionary and protective measures required by the COVID 19 pandemic. The Committee has appreciated the expertise and community input on various topics heard at the monthly meetings. Speakers at Committee meetings included:

- Francesca Tenenbaum, Director of Patient's Rights Advocates of Alameda County, a program of the Mental Health Association of Alameda, which monitors psychiatric facilities for compliance with codes and regulations, and investigates complaints of abuse and neglect at those facilities;
- Kate Jones, Director of Adult/Older Adult Services at Alameda County BHCS;
- Terri Daugherty and Gloria Sawiris, who provided an overview of services provided at John George Psychiatric Pavilion; and
- Kerry Abbott, Director of Homeless Care and Coordination at Alameda County Health Care Services Agency, Teresa Pasquini and Lauren Rettagliata, former members of the Contra Costa Mental Health Advisory Board, and Margo Dashiell, with the East Bay Supportive Housing Coalition.

The Adult Committee also spearheaded the March 3, 2021, letter from the MHAB to Alameda Health System and the Board of Supervisors raising concerns about the proposed closure of the Inpatient Outreach Programs.

Children's Committee

The Children's Committee held monthly meetings. One of the central focuses of those meetings was the serious impact the pandemic has had on children and on transitional age youth (TAY) and how that has impacted the mental health care they receive. Speakers included:

- Nathan Hobbs, ACBH Alcohol and Drug Program Administrator, who presented on substance abuse services for this population;
- Damon Eaves, Associate Director of Children's System of Care, who led a discussion about Telehealth and the challenges created by virtual learning and therapy sessions, since many services for young people are school based; (Lisa Carlisle, Dirctor of Child and Young Adult System of Care, also presented. Damon retired.)
- Representatives of Boldly Me and the Office of Family Empowerment;
- MHAB member Jessie Slafter, who led a discussion on dependent youth and gaps in services for this population, including the limitation on the number of beds for young people who may be struggling with substance abuse.

Conclusion/ Next Steps

The MHAB is proud of its work over the last year and looks forward to another productive year ahead. While we cannot predict all of the challenging issues we will face, we do plan to provide a response to the April 22, 2021 Report of the U.S. Department of Justice Civil Rights Division, "Investigation of Alameda County, John George Psychiatric Hospital and Santa Rita Jail," which describes serious gaps in the County's mental health care system and details the appalling conditions at Santa Rita Jail. The Criminal Justice Committee dedicated one of its meetings to the report, where it had the opportunity to hear from and question Department of Justice

Attorney Jessica Polansky. During that meeting, the Committee also heard from many family members who were deeply concerned about the report's failure to acknowledge the critical need for acute and subacute facilities. The MHAB shares that concern.

The MHAB is excited to support the Board of Supervisors' "Care First, Jail Last" Resolution and to work with the varied array of supportive stakeholders on the implementation of the Resolution. We applaud the Board of Supervisors for its public commitment to a shift in priorities from incarceration to evidence-based mental health treatment.

The MHAB also looks forward to finalizing the monitoring framework and structure that has been proposed to ensure that the MHAB carries out its statutory oversight duties in an efficient and effective manner.

Please let us know if you have any questions or comments about this report. Thank you for giving the members of the MHAB the opportunity to be of service to you and to our community.

Sincerely,

Lee Davis, MHAB Chair

L.D. Louis, MHAB Vice-Chair